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TITLE 9. HEALTH SERVICES

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ARTICLE 1. RULES OF PRACTICE AND PROCEDURE

R9-1-101. Definitions

In this Article, unless the context otherwise requires:

1. "Attorney General" means the Attorney General of the state of Arizona and his designees.
2. "Complaint" means a formal written charge, brought by the Department after investigation, inspection or review to initiate formal proceedings.
3. "Department" means the Arizona Department of Health Services.
4. "Director" means the Director of the Arizona Department of Health Services or his designees.
5. "Hearing officer" means an individual appointed by the Director pursuant to A.R.S. § 36-112(A) to conduct hearings or other proceedings.
6. "Interested person" means any individual or organization permitted by statute or rule to make a statement at a hearing but lacking sufficient interest to be admitted as a party.
7. "Party" means each person or agency named or admitted as a party or properly seeking and entitled as of right to be admitted as a party.

Historical Note

Adopted effective April 13, 1990 (Supp. 90-2).

R9-1-102. Initiation of a hearing

A. A hearing may be initiated only by the Department or by a person whose legal rights, duties, or privileges are required by statute, rule or as otherwise provided by law to be determined after an opportunity for a hearing.

B. A hearing shall be initiated in the manner provided by the statute or rule authorizing the hearing.

1. When a hearing is initiated by a request for hearing served upon the Department, the request for hearing shall be in writing and shall clearly cite:
   a. The specific actions of the Department which are the basis of the hearing request; and
   b. The statute or rule entitling the person to a hearing.

2. Whenever the Department initiates a hearing, the Director shall serve a copy of the notice of proceedings on the named parties. The notice shall comply with A.R.S. § 41-1061(B) and shall be signed by the Director.

Historical Note
Adopted effective April 13, 1990 (Supp 90-2).

R9-1-103. Denial of request for hearing

If the Director denies the request for hearing, the Department shall provide to the applicant a written copy of the decision stating the reasons for denial.

Historical Note
Adopted effective April 13, 1990 (Supp 90-2).

R9-1-104. Hearing officer; disqualification; substitution

A. The Director or a designee may serve as hearing officer.

B. Any hearing officer is subject to disqualification. Any party may petition under A.R.S. § 36-112(B) for the disqualification of a hearing officer within five days of receipt of notice indicating the hearing officer's identity or upon discovering facts indicating grounds for disqualification.

C. The Director shall appoint a substitute hearing officer to replace a disqualified or unavailable hearing officer.

Historical Note
Adopted effective April 13, 1990 (Supp 90-2).

R9-1-105. Communications regarding matters related to a contested hearing

The parties, legal counsel and any person who may be affected by the outcome of a contested case shall not communicate with the Director, Department personnel who assist the Director in rendering a decision, or the hearing officer concerning any matter related to the proceeding prior to a final decision and order, except in the presence of all parties or their counsel or, if in writing, with copies to the Department, the Attorney General and all parties. Anyone receiving a prohibited communication shall promptly file a copy of written communication or summary of oral communication with the Department and serve copies of the same on each party and the Attorney General. The hearing officer shall give all other parties reasonable opportunity to respond to the communication.

Historical Note
Adopted effective April 13, 1990 (Supp 90-2).

R9-1-106. Representation

Any party may participate in the hearing in person or through legal counsel, except that a person other than an individual shall be represented by an attorney. A partnership may appear through any partner and an association through a key administrator or other executive officer. A party shall pay for its own legal representation.

Historical Note
Adopted effective April 13, 1990 (Supp 90-2).

R9-1-107. Notice of hearing or prehearing conference

A. The hearing officer shall set the time and place of the hearing or prehearing conference and give written notice to all parties and to all persons who have filed written petitions to intervene in the matter.

B. The notice shall contain:

1. The official file or other reference number, the name of the proceeding, and a general description of the subject matter;
2. The time, place and nature of the prehearing conference or hearing;
3. A statement of the legal authority and jurisdiction under which the prehearing conference and the hearing are to be held;
4. The name, official title, mailing address and telephone number of the hearing officer for the prehearing conference or hearing;
5. A statement that a party who fails to attend or participate in a prehearing conference, hearing or other stage of a hearing may be held in default; and
6. The names and mailing addresses of persons to whom notice is being given, including any counsel or employee who has been designated to appear for the Department.

C. The notice may include any other matters that the hearing officer considers desirable to expedite the proceedings.

Historical Note
Adopted effective April 13, 1990 (Supp 90-2).

R9-1-108. Prehearing conference, procedure and prehearing order

A. Any party may request a prehearing conference. The hearing officer shall determine whether a prehearing conference is necessary to deal with matters listed in subsection (B) of this Section. The hearing officer shall promptly notify the Department and the parties as provided in R9-1-107 if a prehearing conference is to be held.

B. The hearing officer shall conduct the prehearing conference to deal with settlement, stipulations, clarification of issues, rulings on identity and limitation of the number of witnesses, objections to proffers of evidence, use of written presentation for direct evidence, rebuttal evidence, or cross-examination; use of telephone, television, or other electronic means as a substitute for proceedings in person; order of presentation of evidence and cross-examination, rulings regarding issuance of subpoenas, discovery orders and protective orders; and such other matters as will promote the orderly and prompt conduct of the hearing. The hearing officer shall issue a prehearing order incorporating the matters determined at the prehearing conference.

C. The hearing officer may conduct all or part of the prehearing conference by telephone, television, or other electronic means so long as each participant in the conference has an opportunity to participate during the entire proceeding.

D. If a prehearing conference is not held, the hearing officer may issue a prehearing order, based on the pleadings, to regulate the conduct of the proceedings.

Historical Note
Adopted effective April 13, 1990 (Supp 90-2).

R9-1-109. Pleadings, briefs, motions

The hearing officer, at appropriate stages of the proceedings:

1. shall give all parties full opportunity to file pleadings, motions, objections and offers of settlement.
2. may give all parties full opportunity to file briefs, proposed findings of fact and conclusions of law.

Historical Note
Adopted effective April 13, 1990 (Supp 90-2).

R9-1-110. Filing; computation of time; extension of time

A. The Director shall maintain a docket of all proceedings and shall assign each proceeding a number.

B. All papers in any proceeding shall be filed in the office of the Director, Arizona Department of Health Services, 1740 West Adams Street, Phoenix, Arizona 85007, within the time limit, if any, for such filing. Papers may be transmitted by ordinary or express mail, or otherwise delivered, but must be timely received at the Office of the Director. Service thereof shall be made simultaneously on all parties to the proceeding. A document shall be considered to be filed on the date received by the

Director, established by the date stamp of the Director's Office of Administrative Counsel on its face.

C. Unless otherwise specifically provided in the rules or by an order of the Department, an original and one copy of all papers shall be filed.

D. Wherever these rules provide a specific limitation as to the time within which any papers are required to be filed with the Department in any proceeding, an additional period of seven days shall be available for parties who reside outside of Arizona.

E. In computing any period of time prescribed or allowed by these rules, the day of the act, event or default after which the designated period of time begins to run shall not be included. The last day of the period shall be included unless it is Saturday, Sunday or a state holiday, in which event the period runs until the end of the next day which is neither Saturday, Sunday, nor a state holiday. The computation shall include intermediate Saturdays, Sundays and holidays.

F. For good cause shown, the hearing officer may grant continuances and extensions of time.

Historical Note
Adopted effective April 13, 1990 (Supp 90-2).

R9-1-111. Record of hearings

The Director shall maintain a complete and separate record containing all documents and exhibits filed in connection with each hearing. Such record shall be made available upon request to the public during regular business hours.

Historical Note
Section repealed, new Section adopted effective April 13, 1990 (Supp. 90-2).

R9-1-112. Service; proof of service

A. Service of process shall be required with respect to documents under this article. The party responsible for filing the document shall serve it. The original shall be filed with and retained by the Department and a copy shall be served on each party. Service shall be complete at the time of personal service, the date indicated on the return receipt if served by certified mail, or the date when placed in the mail if served by regular mail.

B. The following shall establish proof of service:
1. If transmitted by certified mail, the return of the signed return receipt; or
2. If personally served, filing with the Department a sworn affidavit stating when, how and by whom the document was served and the date of such service.

C. Requirements for service of documents shall be:
1. For complaints, notices of hearing or prehearing conference, decisions or final orders of the Director, transmission either by personal service or by certified mail to the correct address of record; if served on a corporation, partnership, or association, delivery to the statutory agent, corporate officer, partner, owner or co-owner, or appropriate agent.
2. For all other documents, either by personal service, or by certified or regular mail to the correct address of record.
3. When a party is represented by an attorney, service shall be made on such attorney.

Historical Note
Section repealed, new Section adopted effective April 13, 1990 (Supp. 90-2).

R9-1-113. Default

A. If a party fails to attend or participate in a prehearing conference, hearing, or other stage of a hearing, the hearing officer may serve upon all parties a proposed default order, including a statement of the grounds, with regard to the non-participating party.

B. Within seven days after service of a proposed default order:
1. The party against whom it was issued may file a written motion requesting that the proposed default order be vacated and stating the grounds relied upon.
2. The hearing officer may adjourn the proceedings or conduct them without the party against whom a proposed default order was issued, maintaining due regard for the interests of justice and the orderly and prompt conduct of the proceedings.

C. The hearing officer shall either issue or vacate the default order promptly after expiration of the time specified in subsection (B) or upon filing of the motion.

D. After issuing a default order, the hearing officer shall conduct any further proceedings necessary to complete the adjudication without the defaulting party and shall determine ail issues in the hearing, including those affecting that party.

Historical Note
Amended Regulation 10-71. Section repealed, new Section adopted effective April 13, 1990 (Supp. 90-2).

R9-1-114. Intervention

A. A person seeking to intervene in any hearing shall file a petition for intervention, specifying why the petition should be granted.

B. Requirements for petitions for intervention are:
1. A petition shall be filed with the Department and served upon all parties at least 15 days prior to the hearing.
2. A petition shall demonstrate that the petitioner's legal interests may be substantially affected by the hearing.
3. Any party may file a response to the petition for intervention within five days of service of the petition upon the party. A copy of the response shall be served upon each party.

C. The hearing officer shall consider the following in deciding on the petition:
1. Whether the proposed petition for intervention is in the interests of justice.
2. Whether it may unduly delay or prejudice the hearing.
3. Whether the applicant's interest is represented by any other party to the hearing.

D. The hearing officer shall decide on the petition for intervention at least three days prior to the hearing date and shall promptly notify the petitioner and all parties of the decision. The hearing officer may continue a hearing or provide for a prehearing conference or both to give a party sufficient time to prepare for the hearing or to file a response to the petition.

E. The hearing officer may limit the intervener's participation to issues in which the intervener has a particular interest as demonstrated in the petition.

Historical Note
Amended Regulation 1-74. Section repealed, new Section adopted effective April 13, 1990 (Supp. 90-2).

R9-1-115. Subpoenas

A. The hearing officer may issue a subpoena pursuant to A.R.S. § 41-1062(A)(4), either at the hearing officer's discretion or at the request of any party. The hearing officer may decline to issue a subpoena for irrelevant, immaterial or cumulative evidence.

B. A request for subpoena shall be in writing, filed with the Department and served on each party at least seven days prior to the date set for hearing and shall state:
1. The identification of the person or document requested;

2. All addresses at which the subpoena shall be served; and
3. The facts expected to be established by the person or document subpoenaed, which are necessary for a determination of relevancy and materiality.

C. If more than two subpoenas are requested to establish a single fact in dispute, the request for subpoena must state the reason why the additional subpoena is not merely repetitive.

D. The person to whom a subpoena is directed shall comply with its provisions unless, prior to the date set for hearing, the hearing officer grants a written request to quash or modify the subpoena. The request shall briefly, but thoroughly, state the reasons therefor. The hearing officer shall grant or deny such request by order.

E. The party requesting the subpoena shall serve it upon the person to whom it is directed.

Historical Note
Amended Regulation 10-71. Section repealed, new Section adopted effective April 13, 1990 (Supp. 90-2).

R9-1-116. Procedure at hearing

At a hearing:

1. The hearing officer shall regulate the course of the proceedings and shall conform with any prehearing order.
2. To enable disclosure of relevant facts and issues, the hearing officer shall give all parties the opportunity to testify, respond, present evidence and argument, present witnesses, conduct examination and cross-examination, and submit rebuttal evidence, except as restricted by a limited grant of intervention or by the prehearing order.
3. The hearing officer may give nonparties an opportunity to present, under oath, oral or written statements. The hearing officer shall give all parties an opportunity to cross-examine the witness, challenge or rebut the statement.
4. The hearing officer may conduct all or part of the hearing by telephone, television or other electronic means, so long as each party or interested party has an opportunity to participate in the entire proceeding as it takes place.
5. All hearings are open to public observation, except where closed pursuant to an express provision of law. A hearing conducted by telephone, television or other electronic means shall be made available to members of the public by the opportunity, during regular office hours, to hear or inspect the record of the Department, and to inspect any transcript of the hearing obtained by the Department.

Historical Note
Amended Regulation 10-71. Section repealed, new Section adopted effective April 13, 1990 (Supp. 90-2).

R9-1-117. Evidence

A. All witnesses at a hearing shall testify under oath or affirmation. All parties shall have the right to present such oral or documentary evidence and to conduct such cross-examination as may be required for a full and true disclosure of the facts. The hearing officer shall receive relevant, probative and material evidence, rule upon offers of proof, and exclude all evidence the hearing officer has determined to be irrelevant, immaterial or unduly repetitious. The hearing officer shall admit the kind of evidence on which reasonably prudent people would rely, even if it would be inadmissible in a civil court trial.

B. Unless otherwise ordered by the hearing officer, documentary evidence shall be limited in size when folded to 8 1/2 x 11 inches. The submitting party shall furnish a copy of each documentary exhibit to each party of record present, and three additional copies shall be furnished to the Department, unless the Department or hearing officer otherwise directs. When relevant and material matter offered in evidence by any party appears in a larger work, containing other information, the party shall plainly designate the offered matter. It the other matter is in such volume as would unnecessarily encumber the record, such book, paper or document shall not be received in evidence but may be marked for identification and, if properly authenticated, the relevant and material matter may be read into or photocopied for the record. All documentary evidence offered shall be subject to appropriate and timely objection. When ordered by the hearing officer, the parties shall exchange copies of exhibits prior to or at the hearing.

Historical Note
Amended Regulation 10-71. Section repealed, new Section adopted effective April 13, 1990 (Supp. 90-2).

R9-1-118. Recommended decision; Director's decision

A. If the hearing officer is the Director, the hearing officer shall render a decision.

B. If the hearing officer is not the Director, the hearing officer shall render a recommended decision pursuant to A.R.S. § 36-112(C).

C. A decision or recommended decision shall include separately stated findings of fact, conclusions of law, and policy reasons for the decision if it is an exercise of the Director's discretion, including the reasoning for the remedy recommended.

D. Findings of fact shall be as required by A.R.S. § 41-1061(G). The experience, technical competence, or specialized knowledge of the hearing officer may be utilized in evaluating evidence.

E. If a substitute hearing officer is appointed under Section R9-1-104, the substitute hearing officer shall use any existing record and may conduct further appropriate proceedings in the interests of justice.

F. The hearing officer may allow the parties a designated amount of time after the hearing to submit proposed findings.

G. A recommended decision pursuant to this Section shall be rendered within 30 days after conclusion of the hearing or after submission of proposed findings under subsection (F), unless the Director waives or extends this period for good cause.

H. The recommended decision shall be delivered to the Director.

I. The Director may transmit a copy of the recommended decision to each party who shall then have ten days from the date of service to file a memorandum of objections or exceptions to it. The memorandum shall detail reasons why the recommended decision is in error, with appropriate citations to the record, statutes, rules and other authority. The Director may consider such memorandum in making a decision but shall not consider untimely or unsupported memoranda. A recommended decision snail not be subject to a request for review, rehearing or judicial review.

Historical Note
Amended Regulation 10-71. Section repealed, new Section adopted effective April 13, 1990 (Supp. 90-2).

R9-1-119. Director's decision

Within 30 calendar days after either receipt of any recommended decision from the hearing officer or the final day for filing a memorandum of comments or exceptions to the recommended decision, together with any sufficient, timely exceptions filed, the Director shall issue a decision as provided in A.R.S. § 36-112(C). When the Director is the hearing officer, the decision shall be issued within 60 days following the final day of the hearing.

Historical Note
Amended Regulation 10-71 and 1-74. Section repealed, new Section adopted effective April 13, 1990 (Supp. 90-2).

R9-1-120. Rehearing or review of decision

A. Except as provided in subsection (E), any party to a hearing before the Department who is aggrieved by a decision rendered in such case may file with the Director, not later than 15 days from the date of service of the decision, a written request for rehearing or review of the decision. The request shall specify the particular grounds for rehearing or review. The requesting party shall serve copies upon all other parties in compliance with Section R9-1-112.

B. A request for rehearing or review under this rule may be amended at any time before it is ruled upon by the Director. Any party may file a response to the request for rehearing or review within ten days after service of the request on that party. The Director may require the filing of written argument on the issues raised in the motion and may provide for oral argument.

C. A rehearing or review of the decision may be granted for any of the following causes which materially affect the requesting party's rights:

1. Irregularity in the hearing of the Department or its hearing officer or the prevailing party, or any order or abuse of discretion, whereby the requesting party was deprived of a fair hearing;
2. Misconduct of the Department, its hearing officer or the prevailing party;
3. Accident or surprise which could not have been prevented by ordinary prudence;
4. Newly discovered material evidence which could not with reasonable diligence have been discovered and produced at the original hearing;
5. Excessive or insufficient penalties;
6. Error in the admission or rejection of evidence or other errors of law occurring at the hearing; or
7. The decision is not justified by the evidence or is contrary to law.

D. The Director may affirm or modify the decision or grant a rehearing to the requesting party on all or part of the issues for any of the reasons set forth in subsection (C). An order granting a rehearing shall specify with particularity the grounds on which the rehearing is granted, and the rehearing shall cover only those matters specified. All parties to the hearing may participate as parties at any rehearing.

E. The Director may, on his own initiative, order a rehearing or review of a decision within 15 days after a decision is rendered, for any reason for which a rehearing on motion of a party might have been granted. The order granting such a rehearing shall specify the grounds therefor.

Historical Note

Amended Regulation 10-71. Section repealed, new Section adopted effective April 13, 1990 (Supp. 90-2).

R9-1-121. Effectiveness of orders

A. Unless otherwise stated in the Director's decision, a decision becomes a final order, in accordance with Section R9-1-119, as follows:

1. When the decision is rendered, if further review is unavailable;
2. Fifteen days after service of the decision, if no party has filed a petition for review or reconsideration.

B. Unless otherwise stated in the final order, the final order is effective on the date of service upon a party.

Historical Note

Section repealed, new Section adopted effective April 13, 1990 (Supp. 90-2).

R9-1-122. Repealed

Historical Note

Amended Regulation 10-71 and 1-74. Repealed effective April 13, 1990 (Supp. 90-2).

R9-1-123. Repealed

Historical Note

Amended Regulation 10-71. Repealed effective April 13, 1990 (Supp. 90-2).

R9-1-124. Repealed

Historical Note

Repealed effective April 13, 1990 (Supp. 90-2).

R9-1-125. Repealed

Historical Note

Former Section R9-1-125 renumbered as Section R9-1-126, new Section R9-1-125 adopted effective May 12, 1977 (Supp. 77-3). Repealed effective April 13, 1990 (Supp. 90-2).

R9-1-126. Repealed

Historical Note

Former Section R9-1-125 renumbered as Section R9-1-126 effective May 12, 1977 (Supp. 77-3). Repealed effective April 13, 1990 (Supp. 90-2).

ARTICLE 2. PUBLIC PARTICIPATION IN RULEMAKING

R9-1-201. Agency record

The official rulemaking record is located in the Office of the Director and may be reviewed any working day, Monday through Friday, from 8:00 a.m. until 5:00 p.m. except state holidays.

Historical Note

Adopted effective April 13, 1990 (Supp. 90-2).

R9-1-202. Petition for adoption of rule

A petition to adopt, amend or repeal a rule, pursuant to A.R.S. § 41-1033, shall be filed with the Director as prescribed in this Section. Each petition shall contain:

1. The name and current address of the person submitting the petition.
2. For the adoption of a new rule, the specific language of the proposed rule.
3. For the amendment of a current rule, the citation for the applicable A.A.C. number and title. Included in the request shall be the specific language of the current rule; any language to be deleted shall be stricken through but legible, and any new language shall be underlined.
4. For the repeal of a current rule, the citation for the applicable A.A.C. number and title of the rule proposed for repeal.
5. The reasons the rule should be adopted, amended or repealed, specifically stating in reference to an existing rule, why the rule is inadequate, unreasonable, unduly burdensome, or otherwise not acceptable. Additional supporting information for the petition may be provided, including:
   a. Any statistical data or other justification, with clear references to attached exhibits;
   b. An identification of what persons or segment of the public would be affected and how they would be affected; and
   c. If the petitioner is a public agency, a summary of relevant issues raised in any public hearing, or any written comments offered by the public.

6. The signature of the person submitting the petition.

Historical Note
Adopted effective April 13, 1990 (Supp. 90-2).

R9-1-203. Public comments

A. Any person may comment upon a rule proposed by the Department by submitting written comments on the proposed rule to the Director.

B. Any document is considered to have been submitted on the date it is received by the Department. If a document is mailed, the date of receipt shall be the postmarked date.

C. All written comments received pursuant to A.R.S. § 41-1023 shall be considered by the Department.

Historical Note
Adopted effective April 13, 1990 (Supp. 90-2).

R9-1-204. Oral proceedings

A. Requests for oral proceedings, as prescribed in A.R.S. § 41-1023(B), shall:
1. Be filed with the Director;
2. Include the name and current address of the person making the request; and
3. Refer to the proposed rule and include, if known, the date and issue of the Register in which the notice was published.

B. The oral proceeding shall be recorded either by an electronic recording device or stenographically, and any resulting cassette tapes or transcripts, registers and all written comments received shall become part of the official record.

C. The presiding officer shall utilize the following guidelines to conduct oral proceedings:
1. Voluntary registration of attendees.
2. Registration of persons intending to speak. Registration information shall include the registrant's name, representative capacity, if applicable, a notation of their position with regard to the proposed rule and the approximate length of time they wish to speak.
3. Opening of the record. The presiding officer shall open the proceeding by identifying the rules to be considered, the location, date, time and purpose of the proceeding, and present the agenda.
4. A statement by Department representatives. The statement shall explain the background and general content of the proposed rules.
5. A public oral comment period. Comments may be limited to a reasonable time period, as determined by the presiding officer. Oral comments may be limited to prevent undue repetition.
6. Closing remarks. The presiding officer shall announce the location where the written public comments are to be received and the date and time of the close of record.

Historical Note
Adopted effective April 13, 1990 (Supp. 90-2).

R9-1-205. Petition for delayed effective date

A. A written petition to delay the effective date of the rule, pursuant to A.R.S. § 41-1032 shall be filed with the Director. The petition shall contain:
1. The name and current address of the person submitting the petition;
2. Identification of the proposed rule;
3. The need for the delay, specifying the undue hardship or other adverse impact that may result if the request for a delayed effective date is not granted, and the reasons why the public interest will not be harmed by the later date; and
4. The signature of the person submitting the petition.

B. The Department shall make a decision and notify the petitioner of the decision within 60 days of receipt of the petition.

Historical Note
Adopted effective April 13, 1990 (Supp. 90-2).

R9-1-206. Written criticism of rule

A. Any person may file a written criticism of an existing rule with the Director.

B. The criticism shall clearly identify the rule addressed and specify why the existing rule is inadequate, unduly burdensome, unreasonable or otherwise considered to be improper.

C. The Director shall acknowledge receipt of any criticism within ten working days and shall place the criticism in the official record for review by the Department pursuant to A.R.S. § 41-1054.

Historical Note
Adopted effective April 13, 1990 (Supp. 90-2).

ARTICLE 3. DISCLOSURE OF INFORMATION AND RECORDS

R9-1-301. Reserved

R9-1-302. Reserved

R9-1-303. Reserved

R9-1-304. Reserved

R9-1-305. Reserved

R9-1-306. Reserved

R9-1-307. Reserved

R9-1-308. Reserved

R9-1-309. Reserved

R9-1-310. Reserved

R9-1-311. Definitions

A. "Medical information", as used in this Article, shall include all clinical records, medical reports, laboratory statements or reports, any file, film, record or report or oral statement relating to diagnostic findings and treatment of patients, as well as information relating to contacts, suspects and associates of communicable disease patients.

B. "Employee", as used in this Article, shall include all officers and employees of the Department and of any local health department, including those who may be loaned or assigned by the Department or local health departments by another governmental or private health agency and including consultants paid on a fee basis by the Department or a local health department.

C. "Department" means the Arizona Department of Health Services.

D. "Local health department", as used in this Article, means any district, county or city health department or any combination thereof.

E. "Director" means the Director of the Department of Health Services.

R9-1-312. Prohibition against disclosure

No disclosure by any employee of any medical information in his possession or in the possession of the Department or of any local health department which relates to any identifiable individual or his family shall be made, directly or indirectly, except as authorized in this Article.

R9-1-313. Authority for refusal to disclose

Any request or demand for medical information, disclosure of which is forbidden by this Article, shall be declined upon the authority of this Article and A.R.S. §§ 36-107 and 36-136(G)(18). If any employee is sought to be required, by subpoena or otherwise, to produce such medical information, he shall respectfully decline to present or divulge the same, basing his refusal upon the provisions of law and this Article prescribed thereunder and shall through established administrative channels seek the advice of the appropriate county attorney or the Attorney General.

R9-1-314. Information which may be disclosed

Medical information required by R9-1-312 to be kept confidential is hereby authorized to be disclosed in the following cases and for the following purposes:

1. At the request or with the permission of the person or persons concerning whom the medical information directly relates. If such a person is a minor or an incompetent, such request or permission shall be obtained from his parent or guardian.
2. Any medical information relating to the death of a person may be furnished to his surviving spouse or relative or the legal representative of his estate upon the written request of such qualified person.
3. With proper administrative approval, to any physician, nurse or other paramedical personnel or to any officer or employee of any federal, state or local government or non-profit institution or foundation who, acting in his official capacity and within the scope of his employment, has, within the reasonable discretion of a properly authorized employee who is disclosing or has been requested to disclose such information, a valid purpose for acquiring the same, which purpose is consistent with the administration of a project or program under or with the assistance of the Department, or a local health department or which purpose is to provide medical care to the individual concerned or suspected contacts of such individuals.
4. Where the purpose for which the medical information is sought is not inconsistent with the objectives and purposes of the Department or a local health department and if Departmental administration permits, the Director or in the case of a local health department, the director thereof, may authorize the disclosure of any such information.
5. Authorization for disclosure of information pursuant to this regulation shall not be relied upon to contravene the intent of any statute which specifically prohibits the disclosure of certain information.

R9-1-315. Confidentiality of information received from or through the federal government

Notwithstanding anything in this Article to the contrary, any medical information contained in the records of this Department, the source of which is the Secretary of the U.S. Department of Health, Education and Welfare of any person acting under him or from any provider of services acting as such pursuant to U.S. Public Law 89-97 and any amendments thereto, shall be disclosed only as provided by federal law and the rules and regulations promulgated thereunder.

ARTICLE 4. CODES AND STANDARDS REFERENCED

R9-1-401. Reserved

R9-1-402. Reserved

R9-1-403. Reserved

R9-1-404. Reserved

R9-1-405. Reserved

R9-1-406. Reserved

R9-1-407. Reserved

R9-1-408. Reserved

R9-1-409. Reserved

R9-1-410. Reserved

R9-1-411. Scope and applicability

A. Codes and standards referenced elsewhere in this Title are listed in this Article for convenience in making periodic revisions as new editions become available. Before applying referenced codes and standards, the effective date shown at the end of the applicable regulation within this Article should be checked and the Department or the Secretary of State contacted to assure that the proper edition of the applicable regulation is being utilized.

B. Other jurisdictions -- federal, county, city or other state agencies -- may have applicable requirements which may be additional (such as local zoning ordinances, state and federal occupational safety and health standards) or more restrictive than the minimum requirements established by these rules and regulations (such as local building codes and county health standards).

It is the responsibility of the applicant or licensee, or his agent, to assure that he is in compliance with all such requirements.

C. Where conflicts occur among the standards established in this Title, the following rules of construction shall apply:

1. Standards specified in the narrative portions of the regulations shall govern over the standards adopted by reference.
2. If a conflict occurs among the standards adopted by reference, the more restrictive standard shall govern over the less restrictive.

D. Provisions in the structural codes and standards listed in R9-1-412, relating to purpose, scope, enforcement, exceptions and other administrative matters shall be applied except that:

1. Provisions specifying penalties are excluded from the provisions adopted as regulations.
2. Provisions relating to buildings, structures or facilities subject to licensure by the Department existing at the time an applicable code is adopted, or at the time an existing facility first becomes subject to such provisions, shall be administered in accordance with the following:
   a. Readily correctable deficiencies (those deficiencies posing a hazard which can be corrected to comply with a code adopted by reference within the period ending one year after the expiration of the institution's then existing license) shall be corrected as soon as practicable and before the expiration of the institution's then existing license or, if the Department determines additional time is needed, before the expiration of the next provisional license. The period of time for correction shall begin with the notification by the Department that a deficiency or deficiencies exist as a result of a code adopted by reference and that the deficiency, or each such deficiency, is determined by the Department to pose a hazard to the welfare of patients or employees of the facility. Following such notice the licensee shall meet a reasonable timetable for correction fixed by the Department which shall specify the periods for:
      i. Submission of a satisfactory written plan for correction of the deficiencies, if necessary.

ii. Submission of preliminary drawings, if necessary.
iii. Submission of working drawings, if necessary.
iv. Completion of the modification or construction.

b. Major deficiencies (those deficiencies posing a hazard which cannot be corrected to comply with a code adopted by reference within the maximum period allowable by subparagraph (2)(a)) shall be corrected within three years after being notified by the Department that a major deficiency or major deficiencies exist as a result of a code adopted by reference and that the deficiency or each such deficiency is determined by the Department to pose a hazard to the welfare of patients or employees of the facility. Following such notice the licensee shall meet a reasonable timetable for correction fixed by the Department. The time for completion of construction shall not exceed three years and shall specify the periods for:
i. Submission of a satisfactory written plan for correction of the deficiencies, if necessary.
ii. Submission of preliminary drawings, if necessary.
iii. Submission of working drawings, if necessary.
iv. Completion of the modification or construction.

c. If the plan for correction shows that the entire building in which major deficiencies exist will be replaced with a newly-constructed building, the Department may allow up to two additional years for the completion of construction if it determines that maximum time period allowable under subparagraph (2)(b) is insufficient.

R9-1-412. Physical Plant Health and Safety Codes and Standards

A. When this Section is referenced in a rule contained in Title 9, the following physical plant health and safety codes and standards, incorporated by reference and on file with the Department and the Office of the Secretary of State, and no future amendments or editions shall apply:
1. Uniform Building Code - 1994 edition, Volumes 1 through 3; published by the International Conference of Building Officials, 5360 Workman Mill Road, Whittier, California 90601-2298 (formerly R9-1-412(A)).
2. Uniform Mechanical Code - 1994 edition; published by the International Conference of Building Officials; 5360 Workman Mill Road, Whittier, California 90601-2298 (formerly R9-1-412(C)).
3. Uniform Plumbing Code - 1994 edition; published by the International Association of Plumbing and Mechanical Officials, 20001 Walnut Drive South, Walnut, CA 91789-2825 (formerly R9-1-412(D)).
4. Guidelines for Construction and Equipment of Hospital and Medical Facilities, 1992-93 edition; published by The American Institute of Architects Press, 1735 New York Avenue, N.W., Washington, D.C. 20006 (formerly R9-1-412(F)).
5. National Fire Codes - 1995 editions, Volumes 1 through 12, and 1995 Supplement Part 1 and Part 2, published by the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269-9101 (formerly R9-1- 412(G) and includes the former R9-1-412(B), Life Safety Code, NFPA 101 and the former R9-1-412(E), National Electrical Code, NFPA 70).
6. American National Standard Accessible and Usable Buildings and Facilities, ANSI A117.1 - 1992 edition; published by Council of American Building Officials, 5203 Leesburg Pike, #708, Falls Church, VA 22041 (formerly R9-1-412(H)).
7. Uniform Fire Code - 1994 edition, Volumes 1 and 2; published by the International Fire Code Institute, 9300 Jollyville Road, Suite 105, Austin, TX 78759-7455 (formerly R9-1-412(I).

B. A person shall not be subject to any penalty or fee specified in the physical plant health and safety codes and standards that are incorporated by reference in this Section.

Historical Note
Amended effective December 12, 1975 (Supp. 75-2). Amended effective February 12, 1981 (Supp. 81-1). Amended effective January 5, 1987 (Supp. 87-1). Amended effective April 4, 1994 (Supp. 94-2). Amended effective April 3, 1996 (Supp. 96-2).

R9-1-413. Pediatric and maternity standards

A. Standards for Obstetric-Gynecologic Hospital Services -- 1974 edition; published by the American College of Obstetricians and Gynecologists, One East Wacker Drive, Suite 2700, Chicago, IL 60601; as supplemented by:
1. Standards for Ambulatory Obstetric Care, 1977.
2. Neonatal Intensive Care, 1978.
3. Obstetric, Gynecologic and Neonatal Nursing Functions and Standards, 1974.

B. Standards and Recommendations for Hospital Care of Newborn Infants -- Sixth edition, 1977; published by the American Academy of Pediatrics, P.O. Box 1034, Evanston, IL 60204.

C. Care of Children in Hospitals -- Second edition, 1971; published by the American Academy of Pediatrics, P.O. Box 1034, Evanston, IL 60204.

D. Standards for Day Care Centers for Infants and Children Under 3 Years of Age -- (1971): published by the American Academy of Pediatrics, P.O. Box 1034, Evanston, IL 60204.

Historical Note
Amended effective February 12, 1981 (Supp. 81-1).

R9-1-414. Laboratory procedures standards

A. Manual of Tests for Syphilis, 1969 Edition; Publication 411 of the United States Public Health Service.

B. Standard Methods for the Examination of Water and Wastewater, 14th Edition. American Public Health Association, Washington. D.C., 1976.

C. Methods for Chemical Analysis of Water and Wastes, U.S. Environmental Protection Agency, Office of Technology Transfer, Washington, D.C., 1974.

D. Methods for Organochlorine Pesticides in Industrial Effluents, MDQARL, U.S. Environmental Protection Agency, Cincinnati, Ohio, 1973.

E. Methods for Chlorinated Phenoxy Acid Herbicides in Industrial Effluents, MDQARL, U.S. Environmental Protection Agency, Cincinnati, Ohio, 1973.

F. Interim Radiochemical Methodology for Drinking Water, Environmental Monitoring and Support Laboratory EPA-600/4-75-008, U.S. Environmental Protection Agency, Cincinnati, Ohio 45268.

G. 1976 Annual Book of ASTM Standards, Water and Atmospheric Analysis Part 31, American Society for Testing and Materials, Philadelphia, PA, 1976.

H. Procedures for Radiochemical Analysis of Nuclear Reactor Aqueous Solutions, H.L. Krieger and S. Gold, ERA-R4-73-014. U.S. Environmental Protection Agency, Cincinnati, Ohio, 1973.

I. HASL Procedure Manual, Edited by J.H. Harly, HASL 300, EDRA Health and Safety Laboratory, New York, 1973.

Historical Note
Adopted effective May 26, 1978 (Supp. 78-3).

R9-1-415. Food and drink standards

A. The Vending of Foods and Beverages -- 1978; published by the U.S. Department of Health, Education and Welfare; Public Health Service Food and Drug Administration, DHEW Publication No. (FDA) 78-2091.

B. BISSC Certified Standards of the Baking Industry, as revised through February 1, 1980; published by the Baking Industry Sanitation Standards Committee; 521 Fifth Avenue, New York, NY 10017.

C. Standards 1 through 8 and 12, 18, 20, 26, 29, 35, 37 and C-2 of the National Sanitation Foundation Standards as revised through April 1980; published by the Joint Committee on Food Equipment Standards of the National Sanitation Foundation Headquarters; 2355 West Stadium Blvd.; Ann Arbor, MI.

D. Recommended Dietary Allowances. A report of the Food and Nutrition Board, National Research Council; 1980 edition; published by the National Academy of Sciences, Washington, D.C.

Historical Note
Amended effective February 12, 1981 (Supp. 81-1).
Correction, subsection (A) DHEW Publication number from (FDA) 48-2091 to (FDA) 78-2091 (Supp. 83-3).

R9-1-416. Communicable disease and infection control

A. Isolation Techniques for Use in Hospitals -- D.H.E.W. Publication No. (CDC) 78-8314. Second Edition 1975; U.S. Government Printing Office, Washington, D.C. 20402.

B. Guidelines for Prevention of TB Transmission in Hospitals, D.H.E.W. Publication No. (CDC) 79-8371, 1979; U.S. Government Printing Office, Washington, D.C. 20402.

Historical Note
Amended effective February 12, 1981 (Supp. 81-1).

R9-1-417. Operational codes and standards

A. Inhalation Anesthetics in Ambulatory Care Facilities -- 1975, Standard No. 56, published by the National Fire Protection Association, 470 Atlantic Avenue, Boston, MA 02210.

B. Inhalation Respiratory Therapy -- 1976, Standard No. 56B; published by the National Fire Protection Association, 470 Atlantic Avenue; Boston, MA 02210.

C. Nonflammable Medical Gas Systems, 1977; Standard No. 56F; published by the National Fire Protection Association, 470 Atlantic Avenue, Boston, MA 02210.

D. Medical X-Ray and Gamma-Ray Protection for Energies up to 10 MeV, NCRP Report No. 33, February 1968, published by the National Council on Radiation Protection and Measurements, 4101 Connecticut Avenue, N.W., Washington, D.C. 20008.

Historical Note
Amended effective February 12, 1981 (Supp. 81-1).

R9-1-418. Repealed

Historical Note
Repealed effective February 12, 1981 (Supp. 81-1).

TITLE 9. HEALTH SERVICES

CHAPTER 2. DEPARTMENT OF HEALTH SERVICES TOBACCO TAX-FUNDED PROGRAMS

Editor's Note: This Chapter contains rules which were adopted and amended under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to Laws 1995, Ch. 275, Section 9. Exemption from A.R.S. Title 41, Chapter 6 means that the Department of Health Services did not submit these rules to the Governor's Regulatory Review Council for review; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on these rules; and the Attorney General did not certified these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is being printed on blue paper.

Editor's Note: This Chapter contains rules which were repealed under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department of Health Services did not submit these rules to the Governor's Regulatory Review Council for review; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules on which exempt rulemaking occurred, the Chapter is being printed on blue paper.

ARTICLE 1. SLIDING-FEE SCHEDULE

Article 1, consisting of Section R9-2-101, adopted effective December 18, 1995 (Supp. 95-4).

Article 1, consisting of Sections R9-2-101 through R9-2-111, repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received by the Office of the Secretary of State October 1, 1993.

New Article 1 consisting of Sections R9-2-101 through R9-2-111 adopted effective January 6, 1989.

Former Article 1 consisting of Sections R9-2-111 through R9-2-113, R9-2-211, R9-2-311, R9-2-312, R9-2-411 through R9-2-413, R9-2-511, R9-2-611, and R9-2-612 repealed effective January 6, 1989.

Section
R9-2-101. Approval of Sliding-fee Schedule

ARTICLE 2. HEALTH EDUCATION PROGRAM

Article 2, consisting of R9-2-201 through R9-2-205 adopted effective August 30, 1995, under an exemption from A.R.S. Title 41, Chapter 6.

Section
R9-2-201. Definitions
R9-2-202. Contracts; Expenditures
R9-2-203. Review of Awarded Contracts
R9-2-204. Renumbered
R9-2-205. Renumbered

ARTICLE 3. CHILDREN'S MEDICAL SERVICES PROGRAM

Article 3, consisting of R9-2-301 through R9-2-303, adopted effective September 20, 1996, under an exemption from A.R.S. Title 41, Chapter 6 (Supp. 96-3).

Section
R9-2-301. Matching Funds Requirement
R9-2-302. Funds Use Violations
R9-2-303. Sliding Discount to Fee Schedule

ARTICLE 4. BEHAVIORAL HEALTH SERVICES

Article 4, consisting of R9-2-401 through R9-2-411, adopted effective February 10 1997, under an exemption from A.R.S. Title 41, Chapter 6 (Supp. 97-1).

Section
R9-2-401. Definitions
R9-2-402. Eligible Services
R9-2-403. General Requirements
R9-2-404. Crisis Services
R9-2-405. Joint Regional Behavioral Health Authority and a Qualifying Community Health Center or a School Services
R9-2-406. Wraparound Services for Children
R9-2-407. Behavioral Health Promotion Services for the Elderly
R9-2-408. Outpatient Dually Diagnosed Services
R9-2-409. Regional Behavioral Health Authority and Juvenile Court Collaborative Services
R9-2-410. Regional Behavioral Health Authority Alternative Services
R9-2-411. Special Project Services

ARTICLE 5. RESERVED

ARTICLE 6. RESERVED

ARTICLE 7. REPEALED

Article 7, consisting of Sections R9-2-701 through R9-2-714, repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received by the Office of the Secretary of State October 1, 1993.

ARTICLE 1. SLIDING-FEE SCHEDULE

Editor's Note: The following Section was repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received by the Office of the Secretary of State October 1, 1993. A new Section was subsequently adopted under the regular rulemaking procedure.

R9-2-101. Approval of Sliding-fee Schedule

A. For purposes of this Section, "sliding-fee schedule" means a document that sets forth the relationship between an individual's income and family size and states the percentage of the charges for health care services provided pursuant to A.R.S. § 36-2907.06 for which the individual will be responsible.

B. At least 30 calendar days before implementation of the sliding-fee schedule, a qualifying community health center shall submit an application for approval of the schedule to the Department of Health Services. Submission occurs at the time the Department receives a correctly completed application. The application shall contain:

1. The qualifying community health center's name and street address including city, state, and zip code;
2. The qualifying community health center's telephone number; and
3. The name of the qualifying community health center's administrator.

C. The Department of Health Services shall notify the qualifying community health center in writing of approval or disapproval within 20 calendar days of submission of application. A sliding-fee schedule shall not be implemented without approval. If an application is disapproved, the Department shall set forth the reasons for the disapproval in the written notice. Within 15 calendar days of receiving a written disapproval, a qualifying community health center may file a written request for a hearing with the Department to appeal the disapproval.

D. The sliding fee schedule shall cover income levels from 0 to at least 200% of the federal poverty level.

E. A qualifying community health center shall not deny health care services to an individual eligible for health care services pursuant to A.R.S. § 36-2097.06 because the individual is unable to pay for the health care services.

F. A qualifying community health center shall apply a 100% discount for an eligible individual with an income at or below 100% of the federal poverty level. A qualifying community health center may establish a minimum fee for administrative processing costs for all eligible individuals without regard to income level. A qualifying community health center shall charge the greater of either the administrative fee or the amount of the charges for services for which an eligible individual is determined to be responsible according to the sliding-fee schedule.

G. An individual covered by a sliding-fee schedule shall not be responsible for an amount greater than the amount determined by applying the sliding-fee schedule to the lowest contracted charge for each service received. The lowest contracted charge for a service is determined by reference to contracts covering that service, in effect at the time that the service is rendered, between the qualifying community health center and any payor, subject to limitations of federal and state laws and regulations.

H. The qualifying community health center shall post a notice at or near the main entrance and in each waiting room. The notice shall be in both English and Spanish and shall contain the following information:

1. The qualifying community health center provides primary care services to uninsured Arizona residents with family incomes of 200% or less of the federal poverty guidelines and who meet the eligibility requirements of the Tobacco Tax Primary Care Program, A.R.S. § 36-2907.06.
2. The name of the individual or unit within the qualifying community health center that interested persons may contact to have an eligibility determination interview for the Tobacco Tax Primary Care program.
3. The qualifying community health center's use of an Arizona Department of Health Services-approved sliding-fee schedule to determine the payment responsibility or eligible persons.
4. The name and phone number of the qualifying community health center's staff member responsible for receiving and hearing any complaints from eligible persons regarding their payment responsibility for Tobacco Tax Primary Care program services.

I. The qualifying community health center shall keep a log and file of all complaints dealing with payment responsibility under the sliding-fee schedule. The log and file shall indicate the name and address of the eligible person, the nature of the complaint, the date the complaint was received, the date the decision was rendered, and the date the decision letter was sent to the eligible person. The qualifying community health center shall retain the log and file for 12 months after the decision letter is sent.

Historical Note
Adopted effective January 6, 1989 (Supp. 89-1). Repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received in the Office of the Secretary of State October 1, 1993 (Supp. 93-4). New Section adopted effective December 18, 1995 (Supp. 95-4).

Editor's Note: The following Section was repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received by the Office of the Secretary of State October 1, 1993.

R9-2-102. Repealed

Historical Note
Adopted effective January 6, 1989 (Supp. 89-1). Repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received in the Office of the Secretary of State October 1, 1993 (Supp. 93-4).

Editor's Note: The following Section was repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received by the Office of the Secretary of State October 1, 1993.

R9-2-103. Repealed

Historical Note
Adopted effective January 6, 1989 (Supp. 89-1). Repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received in the Office of the Secretary of State October 1, 1993 (Supp. 93-4).

Editor's Note: The following Section was repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received by the Office of the Secretary of State October 1, 1993.

R9-2-104. Repealed

Historical Note
Adopted effective January 6, 1989 (Supp. 89-1). Repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received in the Office of the Secretary of State October 1, 1993 (Supp. 93-4).

Editor's Note: The following Section was repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received by the Office of the Secretary of State October 1, 1993.

R9-2-105. Repealed

Historical Note
Adopted effective January 6, 1989 (Supp. 89-1). Repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received in the Office of the Secretary of State October 1, 1993 (Supp. 93-4).

Editor's Note: The following Section was repealed effective

September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received by the Office of the Secretary of State October 1, 1993.

R9-2-106. Repealed

Historical Note

Adopted effective January 6, 1989 (Supp. 89-1). Repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received in the Office of the Secretary of State October 1, 1993 (Supp. 93-4).

Editor's Note: The following Section was repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received by the Office of the Secretary of State October 1, 1993.

R9-2-107. Repealed

Historical Note

Adopted effective January 6, 1989 (Supp. 89-1). Repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received in the Office of the Secretary of State October 1, 1993 (Supp. 93-4).

Editor's Note: The following Section was repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received by the Office of the Secretary of State October 1, 1993.

R9-2-108. Repealed

Historical Note

Adopted effective January 6, 1989 (Supp. 89-1). Repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received in the Office of the Secretary of State October 1, 1993 (Supp. 93-4).

Editor's Note: The following Section was repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received by the Office of the Secretary of State October 1, 1993.

R9-2-109. Repealed

Historical Note

Adopted effective January 6, 1989 (Supp. 89-1). Repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received in the Office of the Secretary of State October 1, 1993 (Supp. 93-4).

Editor's Note: The following Section was repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received by the Office of the Secretary of State October 1, 1993.

R2-2-110. Repealed

Historical Note

Adopted effective January 6, 1989 (Supp. 89-1). Repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received in the Office of the Secretary of State October 1, 1993 (Supp. 93-4).

Editor's Note: The following Section was repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received by the Office of the Secretary of State October 1, 1993.

R9-2-111. Repealed

Historical Note

Adopted effective January 6, 1989 (Supp. 89-1). Repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received in the Office of the Secretary of State October 1, 1993 (Supp. 93-4).

ARTICLE 2. HEALTH EDUCATION PROGRAM

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of the Administrative Procedure Act which means that these rules were not reviewed by either the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the agency was not required to hold public hearings on these rules.

R9-2-201. Definitions

For purposes of this Article and A.R.S. § 36-1241.01, unless the context otherwise requires:

1. "Accredited schools, community colleges, and universities" means educational institutions accredited by the New England Association of Schools and Colleges, Middle States Association of Colleges and Secondary Schools, North Central Association of Colleges and Schools, Northwest Association of Schools and Colleges, Southern Association of Colleges and Schools, or the Western Association of Schools and Colleges.
2. "County health department" means a local public health department established pursuant to A.R.S. Title 36, Chapter 1, Article 4.
3. "Department" means the Department of Health Services.
4. "Director" means the Director of the Department of Health Services.
5. "Indian tribe" means any organized Native American nation, group, band, or community recognized by the United States Department of the Interior.
6. "Procurement Code" means A.R.S. Title 41, Chapter 23, and 2 A.A.C. 7.
7. "School" means a school as defined by A.R.S. § 15-101(17), accommodation school as defined by A.R.S. § 15-101(1), charter school as defined by A.R.S. § 15-101(3), or private school as defined by A.R.S. § 15-101(16).

Historical Note

Adopted effective August 30, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9. (Supp. 95-3). Amended effective October 20, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9. (Supp. 95-4).

Editor's Note: The following Section was adopted, repealed, renumbered, and amended under an exemption from the provisions of the Administrative Procedure Act which means that these

rules were not reviewed by either the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the agency was not required to hold public hearings on these rules.

R9-2-202. Contracts; Expenditures

A. Procurement shall be conducted by the Department and the Director in accordance with the Procurement Code. The Director shall effect all contracts and make all decisions required of the Director of the Department of Administration by the Procurement Code.

B. The Director may appoint a review panel to review proposals submitted in response to Requests for Proposals. Evaluation of the proposals shall be based on the evaluation factors set forth in the Request for Proposals and may include, for example, conformance to terms and conditions, scope of work and Request for Proposal requirements, and cost.

C. Administrative expenditures by the Department and the Director shall be made in accordance with A.R.S. § 35-151 et seq. and generally accepted accounting principles as set forth in the *Codification of Governmental Accounting and Financial Reporting Standards*, June 1995, Governmental Accounting Standards Board, P.O. Box 30784, Hartford, CT 06150, which is incorporated by reference and on file with the Office of the Secretary of State.

Historical Note

Adopted effective August 30, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9. (Supp. 95-3). Former Section R9-2-202 repealed, new Section R9-2-202 renumbered from R9-2-204 and amended effective October 20, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9. (Supp. 95-4).

Editor's Note: The following Section was adopted, repealed, renumbered, and amended under an exemption from the provisions of the Administrative Procedure Act which means that these rules were not reviewed by either the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the agency was not required to hold public hearings on these rules.

R9-2-203. Review of Awarded Contracts

Awarded contracts shall be reviewed by the Department in accordance with contract requirements and the Procurement Code.

Historical Note

Adopted effective August 30, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9. (Supp. 95-3). Former Section R9-2-203 repealed, new Section R9-2-203 renumbered from R9-2-205 and amended effective October 20, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9. (Supp. 95-4).

Editor's Note: The following Section was adopted and renumbered under an exemption from the provisions of the Administrative Procedure Act which means that these rules were not reviewed by either the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the agency was not required to hold public hearings on these rules.

R9-2-204. Renumbered

Historical Note

Adopted effective August 30, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9. (Supp. 95-3). Former Section R9-2-204 renumbered to R9-2-202 effective October 20, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9. (Supp. 95-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means that these rules were not reviewed by either the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the agency was not required to hold public hearings on these rules.

R9-2-205. Renumbered

Historical Note

Adopted effective August 30, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9. (Supp. 95-3). Former Section R9-2-205 renumbered to R9-2-203 effective October 20, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9. (Supp. 95-4).

ARTICLE 3. CHILDREN'S MEDICAL SERVICES PROGRAM

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; and the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register. As determined by the agency, public hearings were conducted before adoption pursuant to A.R.S. § 36-2907.08.

R9-2-301. Matching Funds Requirement

A. The applicant shall make available, in pledges from private sources, monies in an amount equal to or more than $1 for each $1 of state funds received under contract with the Children's Medical Services Program.

B. The state grant funds and the matching applicant funds shall be used only for services contracted by the Children's Medical Services Program.

C. The Director shall waive this matching funds requirement in accordance with A.R.S. § 36-2907.08(B)(5).

Historical Note

Adopted effective September 20, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 36-2907.08 (Supp. 96-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; and the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register. As determined by the agency, public hearings were conducted before adoption pursuant to A.R.S. § 36-2907.08.

R9-2-302. Funds Use Violations

A. A contractor shall use grant funds only to provide contracted medical services to children participating in the Children's Medical Services Program. The Department of Health Services shall notify the contractor in writing if a violation is identified.

B. A contractor may appeal a violation notice by filing a written request for a hearing with the Office of the Director within 15 days of receipt of the notice. Appeals shall be conducted in accordance with the Department's rules of practice and procedure, 9 A.A.C. 1, Article 1.

C. The Department shall withhold payment of additional grant funds until an appeal decision is final and payment of any ordered reimbursement and interest penalty is received, if the appeal is denied. An appeal decision is final upon a Director's decision granting the contractor's appeal, or the expiration of the last day for seeking judicial review of the agency order denying the appeal or a later date fixed by order of reviewing court.

D. If a violation notice is not appealed within 15 days, or if an appeal is denied following hearing, the contractor shall reimburse the grant funds found to be used in violation of the terms of the contract to the Department immediately following the 15th day or when the appeal decision is final.

E. An interest penalty of 10% per calendar month, of the total dollar amount found to be used in violation, may be assessed against the contractor for each month the reimbursement is not received. Portions of a calendar month shall be pro-rated.

Historical Note

Adopted effective September 20, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 36-2907.08 (Supp. 96-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; and the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register. As determined by the agency, public hearings were conducted before adoption pursuant to A.R.S. § 36-2907.08.

R9-2-303. Sliding Discount to Fee Schedule

A. For the purpose of this Section, the Sliding Discount to Fee Schedule sets forth the percentage of the charges for medical care services provided pursuant to A.R.S. § 36-2907.08 for which the accountable individual, parent, or guardian shall be responsible.

B. The sliding fee schedule shall apply to income levels below 200% of the federal poverty level.

C. Families with incomes above 200% of federal poverty guidelines shall not be eligible to participate in this program.

D. For families with incomes below 100% of the federal poverty level, the payment shall be zero.

E. For families with incomes between 100% and 200% of the federal poverty level, the following percentages shall be applied to the charges for services provided:

% of Federal Poverty Level from - up to	*% of the Charges for Services Charge*
100 - 110	5%
110 - 120	10%
120 - 130	20%
130 - 140	30%
140 - 150	40%
150 - 160	50%
160 - 170	60%
170 - 180	70%
180 - 190	80%
190 - 200	90%

For purposes of this Section, "up to" means to, but not including, the number that follows.

F. The contractor providing services under this program shall arrange alternative payment mechanisms to allow an accountable individual, parent, or guardian to pay off their portion of the charges over a reasonable period of time, if necessary.

G. The contractor shall keep a log and file of all complaints dealing with payment responsibility under the Sliding Discount to Fee Schedule. The log and file shall indicate the name and address of the eligible person, the nature of the complaint, the date of the complaint, the date the response to the complaint was rendered, and the date the letter responding to the complaint was sent to the responsible person. The log and file shall be available for inspection by department staff during normal business hours.

Historical Note

Adopted effective September 20, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 36-2907.08 (Supp. 96-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and there were no public hearings conducted on the Section.

ARTICLE 4. BEHAVIORAL HEALTH SERVICES

R9-2-401. Definitions

In addition to the definitions prescribed in A.R.S. §§ 36-401, 36-501, 36-2021, and 36-3001, the terms in this Article mean:

1. "BHS" means the Division of Behavioral Health Services located in the Department of Health Services.
2. "Children" means persons who are under the age of 18 years.
3. "Crisis respite" means Department and BHS non-Title XIX, reimbursable services offering planned, short-term placement in a program contracted to provide crisis respite that provides a living environment with staff knowledgeable about how to de-escalate crisis situations and which meets the eligible individual's physical needs.
4. "Culturally relevant" means knowledge, attitudes, and policies within an agency which allows staff to work effectively in cross cultural situations. The knowledge, attitudes and policies include community-based values, traditions, and practices in developing and evaluating interventions, communication, and other activities.
5. "Department" means the Department of Health Services.
6. "Dually diagnosed" means a person, aged 18 or over, who has been determined to be an individual with Serious Mental Illness in accordance with R9-21-301 and R9-21-303; and, who additionally is diagnosed as substance abusive or substance dependent in accordance with the Diagnostic and Statistical Manual IV.
7. "Early Intervention" means assessment and supportive services provided by a peer, behavioral health technician or other qualified behavioral health professional, including peer counseling and direct counseling to individuals, groups or family members, to assess and alleviate potential emerging behavioral health problems before they require difficult, costly or more intensive treatment.
8. "Eligible services" means those services in, R9-2-402, to be implemented with funds authorized under A.R.S. § 36-3414(A).
9. "Intensive Partial Care Services" means services licensed according to R9-20-1603.
10. "Level I or II residential facility" means a behavioral health facility licensed according to R9-20-601 through R9-20-605 or R9-20-701 and R9-20-702.

11. "Mobile Team" means 2 or more behavioral health professionals as defined in R9-20-101 who are trained to do psychiatric crisis intervention 24 hours a day in the community at locations other than a behavioral health treatment facility, and who are certified by the American Heart Association or the American Red Cross to provide cardiopulminary resuscitation, first aid, and counsel clients experiencing acute distress due to behavioral health issues.
12. "Peer Counseling" means a method of counseling that pairs individuals who have been trained by the RBHA or provider and individuals at risk or involved in the behavioral health system with a similar sociodemographic, ethnic, language, cultural background, or other relevant characteristics.
13. "Psychiatrist" means a physician licensed in Arizona under A.R.S. Title 32, Chapter 13 or 17, and Board certified or Board eligible under the standards of the American Board of Psychiatry and Neurology or the Osteopathic Board of Neurology and Psychiatry.
14. "Qualifying Community Health Center" means a community based primary care facility that provides medical care in medically underserved areas through the employment of physicians, professional nurses, physician assistants, or other health care technical and paraprofessional personnel.
15. "Regional Behavioral Health Authority" or "RBHA" means an organization under contract with the Department to coordinate the delivery of behavioral health services in a specific service area of the state for eligible persons.
16. "Service area" means a geographic region of the state with boundaries established by the Department and BHS for the planning, monitoring, and delivery of behavioral health services.
17. "Service Matrix" means a list developed by BHS of Title XIX and Non-Title XIX covered services that may be reimbursed with Title XIX funds county, state, or federal funds for behavioral health disorders.
18. "Title XIX eligible" means a person who has been determined to qualify for Arizona Health Care Cost Containment Services (AHCCCS) Title XIX behavioral health services based upon the individual's income and resources, citizenship, residency, or medical condition.
19. "Underinsured" means an individual who is covered by an individual, family, or group insurance plan from any public or private source which does not include or places a lifetime maximum amount of reimbursement for health care costs related to mental health services, including substance abuse treatment.
20. "Uninsured" means an individual who is not covered by an individual, family, or group insurance plan from any public or private source which includes reimbursement for health care costs related to mental health services including substance abuse treatment.
21. "Wraparound Services" mean a combination of behavioral health services included in the BHS service matrix which are used for the individual needs of children and their families without removal from the community setting.

Historical Note
Adopted effective February 10, 1997, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9 (Supp. 97-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and there were no public hearings conducted on the Section.

R9-2-402. Eligible Services

A. The following services shall be eligible for funding for purposes of A.R.S. § 36-3414:
1. Crisis services,
2. Joint RBHA and a Qualifying Community Health Center or a school service,
3. Wraparound services for children,
4. Behavioral health promotion services for the elderly,
5. Dually diagnosed services,
6. RBHA and juvenile court services,
7. RBHA alternative services, and
8. Special project services.

Historical Note
Adopted effective February 10, 1997, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9 (Supp. 97-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and there were no public hearings conducted on the Section.

R9-2-403. General Requirements

A. BHS shall provide RBHAs with a per capita allocation of available tobacco tax funds for eligible services except special project services.

B. Upon request, a RBHA shall submit a plan to BHS for the expenditure of the allocated tobacco tax funds for eligible services except special project services. The plan shall include:
1. Identification of the planning process used to develop the program and expenditure plan;
2. Identification of the eligible services selected by the RBHA and an implementation schedule;
3. A brief description of the need for each eligible service identified in the plan;
4. Identification of population to be served, services included, and criteria for each eligible service selected;
5. A description of the evaluation methodology to be used; and
6. The expenditure limit for each program priority selected.

C. A RBHA shall obtain prior Department approval to implement a plan for eligible services, except for special project services in R9-2-403 and R9-2-411.

D. A RBHA shall solicit proposals from all interested providers of services for eligible services, except special project services.

E. A RBHA shall submit any proposed changes to an approved plan to ADHS/BHS prior to implementation of the changes. Upon receipt of the proposed changes, BHS shall approve or deny the request within 30 days.

F. For special project services, BHS shall provide to the RBHA a summary of special project services. Special project services shall be limited to 3 years in duration contingent upon available funds.

G. For a RBHA to receive special project service funds:
1. BHS shall notify the RBHAs of its intent to award special project services funds;

2. Within 30 days of the date of the BHS letter of intent to award special project services funds, a RBHA shall submit a letter of interest to BHS regarding implementation of the special project services in its service area. The letter of interest shall include the following:
   a. Identification of unmet need for the service being proposed, specifying the population that will be served;
   b. Summary of proposed implementation plan and time table; and
   c. Objectives to be achieved by the services;
3. A RBHA shall be notified within 30 days of the submittal deadline of the award of special project services funds.

H. A RBHA shall not use funding for eligible services to supplant existing funding. All alternative funding sources should have been or shall be exhausted during the fiscal year of the award for eligible services.

I. A RBHA shall ensure that all eligible services provided are culturally relevant.

J. The RBHA shall ensure that all eligible services are provided by qualified staff in accordance with 9 A.A.C. 20.

K. Reporting and evaluation information shall be forwarded to BHS at intervals established by ADHS/BHS. Requirements include:
1. RBHAs and their subcontractors shall account for Tobacco Tax expenditures separate from other funding sources in a manner prescribed by ADHS/BHS;
2. RBHAs and their subcontractors funded by the Department shall provide the following utilization information:
   a. Level and scope of services being offered,
   b. Type of services being used,
   c. Frequency of service being used,
   d. Personal characteristics of the program participants, and
   e. Demographic characteristics of the program participants.
3. RBHAs and their subcontractors funded by the Department shall provide the following service evaluation information:
   a. The number of participants,
   b. Names of agencies providing eligible services,
   c. Service revenues and expenditures, and
   d. The average cost for each service recipient.

Historical Note

Adopted effective February 10, 1997, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9 (Supp. 97-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and there were no public hearings conducted on the Section.

R9-2-404. Crisis Services

A. Crisis services, as defined in R9-20-901 through R9-20-903, shall be designed to de-escalate crisis situations and provide alternatives to inpatient behavioral health care assessment, stabilization and treatment or incarceration.

B. Crisis services shall be available from a provider licensed by the Department to any non-Title XIX eligible person who is determined by a behavioral health professional as defined in R9-20-101 to be in a crisis situation and in need of the crisis service.

C. Crisis services may include any agency licensed by the Department to provide crisis services such as urgent care centers, crisis stabilization units, crisis respite, mobile teams, or peer counseling.

D. A program shall provide crisis services, including the following:
1. Twenty-four hour response, including phone and face-to-face assessment, for a behavioral health crisis through presentation of the individual needing the service at a facility or through a mobile team.
2. Transportation services for an individual in crisis to receive required crisis services;
3. A psychiatrist accessible 24 hours a day;
4. An initial assessment of an individual in crisis as provided in R9-20-402;
5. A treatment plan for an individual in a crisis as provided in R9-20-404;
6. Client record keeping requirements in accordance with R9-20-407;
7. Security, evaluation, and monitoring of an individual's prescribed medication or medications; and
8. Follow-up care, once the individual's crisis situation is alleviated, including:
   a. A referral of the individual to a licensed behavioral health agency if the individual is not already being treated; and
   b. Notification of the individual's behavioral health treatment agency and the case manager, if assigned, if the individual is currently a client of a licensed behavioral health agency.

Historical Note

Adopted effective February 10, 1997, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9 (Supp. 97-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and there were no public hearings conducted on the Section.

R9-2-405. Joint Regional Behavioral Health Authority and a Qualifying Community Health Center or a School Services

A. Joint RBHA and Qualifying Community Health Center or school services shall provide on-site behavioral health assessments to individuals identified by a behavioral health technician or behavioral health professional as defined in R9-20-101 as having potential behavioral health problems.

B. Joint RBHA and Qualifying Community Health Center or school services shall provide referral to a behavioral health treatment agency licensed by the Department.

C. Joint RBHA and Qualifying Community Health Center or school services shall provide education and information about behavioral health to staff at Qualifying Community Health Centers or schools.

D. Joint RBHA and Qualifying Community Health Center or school services shall serve non-Title XIX eligible individuals who are uninsured or underinsured and who present at Qualifying Community Health Centers or school programs and who may have a behavioral health problem.

E. Joint RBHA and Qualifying Community Health Center or school services shall be offered at a Qualifying Community Health Center or at a school.

Historical Note
Adopted effective February 10, 1997, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9 (Supp. 97-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and there were no public hearings conducted on the Section.

R9-2-406. Wraparound Services for Children

A. A program that provide wraparound services for children shall provide flexible funding to purchase services and items to assist in maintaining a child in the least costly and least restrictive treatment setting.

B. Wraparound services for children shall be provided to non-Title XIX eligible children who are uninsured or underinsured and who are being served by more than 1 state agency, at a minimum including ADHS/BHS through the RBHAs or their provider network.

C. Wraparound services for children shall include 1 or more of the following categories:
1. Personal items for the child or family,
2. Instructional expenses,
3. Transportation,
4. Health and safety items, and
5. Special activities for the child or family.

D. A program for wraparound services for children shall place an established limit on the amount of funds spent per family per year. The RBHA shall submit the established limit in their plan in accordance with R9-2-403(B).

E. In providing wraparound services for children a RBHA shall prepare the following:
1. Documentation in the clinical record as to how the service or item is required to maintain the child in the least restrictive treatment setting;
2. Documentation in the clinical record of the relationship between treatment plan goals and items or services provided with wraparound funding;
3. A plan to assure that an effective interagency collaborative process is in place for the use of the funds;
4. Documentation that case managers and others involved in program administration have received training in the wraparound services concept.

Historical Note
Adopted effective February 10, 1997, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9 (Supp. 97-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and there were no public hearings conducted on the Section.

R9-2-407. Behavioral Health Promotion Services for the Elderly

A. Behavioral health promotion services for the elderly shall maximize the opportunity for elderly individuals to remain in their current living situation.

B. Behavioral health promotion services for the elderly shall serve non-Title XIX eligible individuals age 60 or over with a behavioral health problem or at risk of experiencing a behavioral health problem who are uninsured and underinsured.

C. Behavioral health promotion services for the elderly shall be individualized and may include any service included on the BHS service matrix to meet the needs of the population to be served. The RBHA may also propose to BHS other specialized services which may not be currently included on the matrix. The RBHA's plan, submitted to BHS in accordance with R9-2-403(B), shall identify both service matrix and other specialized services for the elderly. Other specialized services may include:
1. Assistance in the performance of activities of daily living,
2. Nutrition monitoring,
3. Cognitive interventions associated with geriatric related conditions such as dementia and depression,
4. Coordination of physical health needs and direct assistance if required,
5. Medication monitoring,
6. Recreational and socialization activities,
7. Transportation,
8. Financial management assistance,
9. Caregiver respite, and
10. Other services identified by the RBHA and approved by BHS. RBHAs requesting other services must submit a letter of request to BHS.

D. A RBHA which provides behavioral health promotion services for the elderly shall:
1. Consult with professionals who have specialized training and skills in gerontology relative to the design of the program and in ongoing monitoring; and
2. Document in the clinical record the linkage between behavioral health services and medical needs of the elderly person receiving services, with documentation of communication and collaboration occurring with all caregivers and agencies, including the Area Agency on Aging.

Historical Note
Adopted effective February 10, 1997, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9 (Supp. 97-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and there were no public hearings conducted on the Section.

R9-2-408. Outpatient Dually Diagnosed Services

A. A program shall provide outpatient dually diagnosed services to assist individuals who are both Seriously Mentally Ill and substance abusers in the management of their mental illness and recovery from their substance abuse.

B. Outpatient dually diagnosed services shall serve non-title XIX eligible adults aged 21 to 64 who are uninsured or underinsured and also have a dual diagnosis of Serious Mental Illness in accordance with 9 A.A.C. 21 and substance abuse or substance dependence in accordance with the DSM IV.

C. A RBHA providing outpatient dually diagnosed individuals shall include the availability of intensive partial care in accordance with R9-20-1603 followed by outpatient services in accordance with R9-20-1001 through R9-20-1003.

D. A RBHA or program providing outpatient dually diagnosed services shall:
1. Submit written bi-weekly reports to the individual's case manager. The report shall include an assessment of the

progress in meeting treatment plan goals and recommendations for continued placement. The recommendations shall be generated from a face-to-face staffing which includes the primary counselor, the clinical director, and the psychiatrist.

2. Document medication monitoring administration and adjustment in the individual's clinical record and submitted as part of the bi-weekly report to the individual's case manager.
3. Within 30 days of BHS approval of the plan referenced in R9-20-303(B), the RBHA shall submit for review and approval to BHS, the admission, continued stay and discharge criteria for individuals who will be treated in this eligible service.
4. Require at least 1 full time staff person shall be certified as a substance abuse counselor by the Board of Behavioral Health Examiners pursuant to A.R.S. Title 32, Chapter 33 or by the Arizona Board of Certification of Addiction Counselors. Certification shall be documented in the substance abuse counselor's personnel file.

E. The program providing outpatient dually diagnosed services shall provide and document monthly 4-hour specialized training sessions. Staff shall be required to attend 1/2 of the training sessions for a total of 24 hours annually. Specialized training shall include:

1. Pharmacological information about illicit and licit drugs including alcohol,
2. Coping skills for dually diagnosed individuals,
3. Treatment research information on dually diagnosed individuals,
4. Relapse prevention,
5. Communicable diseases including HIV/AIDS, and
6. Any other topic approved by the RBHA.

Historical Note
Adopted effective February 10, 1997, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9 (Supp. 97-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and there were no public hearings conducted on the Section.

R9-2-409. Regional Behavioral Health Authority and Juvenile Court Collaborative Services

A. RBHA and juvenile court collaborative services shall coordinate behavioral health services and criminal justice requirements. Coordination shall be documented by:

1. The prevention or reduction of the length of stay in detention;
2. The provision of alternative placements for children with behavioral health needs, and
3. The reduction of the time required to assess, determine eligibility, and access services for children in detention who have behavioral health needs.

B. RBHA and juvenile court collaborative services shall serve non-Title XIX eligible children who are uninsured or underinsured and who are both in need of behavioral health services and involved in, or at immediate risk for involvement in, the Juvenile Court system. Title XIX eligible children who are in detention and whose behavioral health services are therefore not Title XIX reimbursable shall also be eligible for these services.

C. RBHA and juvenile court collaborative services shall include the following:

1. Assessment for children in detention, or referred to Juvenile Court by parents, who have behavioral health needs as determined by at least the level of personnel identified in R9-20-406(C), behavioral health technician;
2. Alternative placement in lieu of detention;
3. Training and education for behavioral health and detention professionals in topics approved by the RBHA;
4. Parent training to prevent or reduce further involvement of children in the juvenile court system; and
5. Case management for children with behavioral health needs who are leaving incarceration.

Historical Note
Adopted effective February 10, 1997, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9 (Supp. 97-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and there were no public hearings conducted on the Section.

R9-2-410. Regional Behavioral Health Authority Alternative Services

A. In addition to the services identified in R9-2-404 through R9-2-409, the RBHA may identify and propose alternative services.

B. The RBHA shall submit with their program plan identified in R9-2-403(B) any proposed alternative services.

C. The RBHA shall obtain approval from BHS before implementing the plan.

Historical Note
Adopted effective February 10, 1997, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9 (Supp. 97-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and there were no public hearings conducted on the Section.

R9-2-411. Special Project Services

A. Special project services shall be identified by BHS.

B. The following special project services have been identified:

1. Services for ethnic minority children.
   a. Services for ethnic minority children shall assist individuals in accessing behavioral health treatment.
   b. Services for ethnic minority children shall serve non-title XIX eligible who are uninsured or underinsured and who self-assess as non-Anglo who are at risk for or experiencing behavioral health problems.
   c. Services for ethnic minority children shall include prevention and outreach services.
   d. Special project services shall include:
      i. The services shall be available in communities with predominately non-Anglo residents;
      ii. The services shall be located in a RBHA area with a multiple risk factors including: Non-homicide crime rate higher than the state average; homicide rate higher than the state average; teenage pregnancy rate higher than the

state average; school drop-out rate higher than the state average; or any other factor approved by ADHS/BHS.

iii. The services shall be managed and provided by an agency with demonstrated experience in serving ethnic minority children;

iv. The services shall be provided by an agency with a governing board membership which is culturally reflective of the populations served by the agency and the community in which the agency is located.

2. Substance abuse residential treatment services for children.

a. Substance abuse residential treatment for children shall assist children in becoming alcohol and drug free.

b. Substance abuse residential treatment for children shall serve non-Title XIX eligible children who are uninsured or underinsured and who have a primary substance abuse diagnosis and who have at least 1 documented failure in a less intensive level of substance abuse treatment.

c. Substance abuse residential services for children shall include residential treatment in accordance with R9-20-601 through R9-20-605 or R9-20-701 through R9-20-702, followed by outpatient treatment in accordance with R9-20-1001 through R9-20-1003. The residential treatment services shall emphasize family interventions, family involvement, the individual's progress in meeting treatment plan goals and outcome monitoring. Specific short-term residential services shall include the following:

i. Assessment, not less than monthly;

ii. Individual counseling with a minimum of 1 counseling session per week;

iii. Group or family group counseling with a minimum of 5 counseling sessions per week;

iv. Pharmacologic interventions, as appropriate; and

v. Any other service on the BHS service matrix allowable in a residential setting.

d. Outpatient services shall be provided to individuals who have completed the residential treatment. Outpatient services following residential treatment shall emphasize community supports and in-home services, with on-going family involvement. Outpatient services following residential treatment shall be delivered in the community where the individual lives, when possible. Specific outpatient services following residential treatment shall include the following:

i. Individual counseling at least once per week;

ii. Group counseling at least twice per week;

iii. Family counseling at least once per week;

iv. A duration of individual, group, and family counseling for a minimum of 2 months;

v. Following the regimen described in R9-2-411(B)(2)(d), the individual will receive individual counseling at least once per month, group counseling at least once per week, and family counseling for at least once per month for a duration of at least 2 months.

e. The agency providing residential services for children shall employ at least 1 full time staff person certified as a substance abuse counselor by the Board of Behavioral Health Examiners pursuant to A.R.S. Title 32, Chapter 33 or certified by the Arizona Board of Certification of Addiction Counselors. Certification shall be documented in the substance abuse counselor's personnel file.

Historical Note
Adopted effective February 10, 1997, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 9 (Supp. 97-1).

ARTICLE 5. RESERVED

ARTICLE 6. RESERVED

ARTICLE 7. REPEALED

R9-2-701. Reserved

R9-2-702. Reserved

R9-2-703. Reserved

R9-2-704. Reserved

R9-2-705. Reserved

R9-2-706. Reserved

R9-2-707. Reserved

R9-2-708. Reserved

R9-2-709. Reserved

R9-2-710. Reserved

The following Section was repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received by the Office of the Secretary of State October 1, 1993.

R9-2-711. Repealed

Historical Note
Adopted effective November 28, 1977 (Supp. 77-6). Repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received in the Office of the Secretary of State October 1, 1993 (Supp. 93-4).

The following Section was repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received by the Office of the Secretary of State October 1, 1993.

R9-2-712. Repealed

Historical Note
Adopted effective November 28, 1977 (Supp. 77-6). Repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received in the Office of the Secretary of State October 1, 1993 (Supp. 93-4).

The following Section was repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received by the Office of the Secretary of State October 1, 1993.

R9-2-713. Repealed

Historical Note
Adopted effective November 28, 1977 (Supp. 77-6). Repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received in the

Office of the Secretary of State October 1, 1993 (Supp. 93-4).

The following Section was repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received by the Office of the Secretary of State October 1, 1993.

R9-2-714. Repealed

Historical Note

Adopted effective November 28, 1977 (Supp. 77-6). Repealed effective September 30, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1992, Ch. 301, § 61; received in the Office of the Secretary of State October 1, 1993 (Supp. 93-4).

TITLE 9. HEALTH SERVICES

**CHAPTER 3. DEPARTMENT OF HEALTH SERVICES
INJURY CONTROL**

(Authority: A.R.S. § 36-1681(E))

ARTICLE 1. PRIVATE POOL SAFETY NOTICE

Article 1, consisting of Section R9-3-101, adopted effective October 22, 1992 (Supp. 92-2).

Article 1, consisting of Section R9-3-101, adopted by emergency action effective June 16, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2).

R9-3-101. Pool Safety Notice

ARTICLE 1. PRIVATE POOL SAFETY NOTICE

R9-3-101. Pool Safety Notice

The following is the notice explaining safety education and the responsibilities of pool ownership approved in accordance with A.R.S. § 36-1681:

AN IMPORTANT NOTICE ABOUT POOL SAFETY*

Drowning is a serious threat to young children in Arizona. Young children also suffer from a high number of near drownings that may lead to permanent, severe disability. Most of these incidents occur in the child's own backyard swimming pool. These tragedies must be stopped. To that end, the Arizona Legislature has passed a law requiring that new occupants of dwellings with pools, and persons having a pool installed, receive this safety message about steps to prevent drownings and the legal responsibilities of pool ownership.

State of Arizona law requires a barrier between the house and pool.**

This law applies to homes with both a child under 6 years of age and a pool built after June 1, 1991. This law aims to impede children's access to their own pools. Likewise, **all pools must have a barrier to keep out uninvited neighborhood children.**

Unless a local code provides otherwise***, **the barrier must:**

- **Entirely enclose the pool area.**
- **Be at least 5 feet high,** measured on the outside of the barrier.
- **Not have openings, handholds or footholds** that can be used to climb the barrier. Wire mesh or chain link fences shall have a maximum mesh size of 1 3/4 inches measured horizontally.
- **Have no openings through which a sphere 4 inches in diameter can pass.** Horizontal components of any barrier shall be spaced not less than 45 inches apart measured vertically or shall be placed on the pool side of the barrier which shall have no opening greater than 1 3/4 inches measured horizontally.
- **Be at least 20 inches from the water's edge.**
- **Prevent direct access from the house to the pool.**

Gates must be self-closing and self-latching with the latch located at least 54 inches above the ground or on the pool side with a release mechanism at least 5 inches below the top of the gate and no opening greater than 1/2 inch within 24 inches of the release mechanism or be secured by a padlock or similar device which requires a key, electronic opener or integral combination which can have the latch at any height. **Gates must open outward from the pool.**

If a wall of the home forms part of the barrier, one of the following must be used:

- A barrier at least 4 feet high between the home and the pool which otherwise meets all of the requirements for a barrier set forth above.
- A motorized, safety pool cover which does not require manual operation other than the use of a key switch which meets the American Society of Testing and Materials (ASTM) emergency standard 13-89 (now ASTM #F 1346-91).
- Self-latching devices on all doors with direct access to the pool. Such latches shall meet the requirements for latches on self-closing gates set forth above.
- Emergency escape or rescue windows from sleeping rooms with access to the pool shall be equipped with a latching device not less than 54 inches above the floor. All other openable dwelling unit or guest room windows with similar access shall be equipped with a screwed-in-place wire mesh screen, or a keyed lock that prevents opening the window more than 4 inches, or a latching device located not less than 54 inches above the floor.

An above-ground swimming pool shall have non-climbable exterior sides which are a minimum height of 4 feet. Any access ladder or steps shall be removable without tools and secured in an inaccessible position with a latching device not less than 54 inches above the ground when the pool is not in use.

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* Approved pursuant to Arizona Revised Statutes § 36-1681 and A.A.C. R9-3-101.

** "Pool" means an in-ground or above-ground swimming pool or other contained body of water 18 or more inches in depth, wider than 8 feet, and intended for swimming.

*** Phoenix, Peoria, Tucson, and some other cities and unincorporated areas of Maricopa, Pima, and Pinal counties have different pool barrier requirements. Check with your city and county governments to see if they have adopted different pool barrier requirements.

Supervision is the key to prevent drownings.

Never leave children unsupervised in the pool or inside the pool area -- **not even for a second!**

Inform guests to your home of the importance of closely watching children around water. At parties, make sure someone is always watching the children around the pool.

Don't count on barriers to keep children from reaching the pool. **No barrier is foolproof.** Barriers only slow a child's access to the pool.

In case of an emergency: act immediately -

1 - Shout for help.

2 - Pull the child out of the water.

3 - Take the child to the phone and dial 911 (or the local emergency number) for help.

4 - Check airway and breathing. If needed, start CPR immediately. CPR can save lives and prevent serious injury.

Other smart tips to protect children around water:

DON'T:

- Don't keep toys, tricycles or other playthings in the pool area. Also, remove items that a child could use to climb over the barrier.
- Don't be distracted by phone calls, doorbells, or chores while children are in the pool. Your full attention should be on the children.
- Don't rely on swimming lessons or "floaties" to protect your children.
- Don't prop gates open.

DO:

- Attend a CPR class. All family members and babysitters should know CPR. For the nearest class, contact your local fire department.
- Post *911* (or the local emergency number) on all phones.
- Learn water rescue. Keep lifesaving equipment mounted near the pool, especially if you can't swim.
- Lock passageways (such as pet doors) leading to the pool.
- Inspect latches and gates regularly; keep them in working order.
- Set a good example. Insist on safety around the pool.

□ ADHS-DDP-OCDE; 27 AUG 1992 □

Historical Note

Emergency rule adopted effective June 16, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Adopted effective October 22, 1992 (Supp. 92-4).

TITLE 9. HEALTH SERVICES

CHAPTER 4. DEPARTMENT OF HEALTH SERVICES NONCOMMUNICABLE DISEASES

ARTICLE 1. DEFINITIONS

Section
R9-4-101. Definitions, general
R9-4-102. Pesticide Illness
R9-4-103. Definitions: Blood Lead Levels
R9-4-104. Definitions, Cancer Registry
R9-4-105. Definitions, birth defects monitoring program

ARTICLE 2. PESTICIDE ILLNESS

R9-4-201. Pesticide Illness Reporting Requirements

ARTICLE 3. BLOOD LEAD LEVELS

R9-4-301. Reporting Significant Blood Lead Levels

ARTICLE 4. CANCER REGISTRY

R9-4-401. Case reporting
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R9-4-403. Data quality assurance
R9-4-404. Effective date

ARTICLE 5. BIRTH DEFECTS MONITORING PROGRAM

R9-4-501. Procedures; access to medical records

ARTICLE 1. DEFINITIONS

R9-4-101. Definitions, general

In this Chapter, unless the context otherwise requires:

1. "Dentist" means any person licensed under the provisions of A.R.S. Title 32, Chapter 11.
2. "Hospital" means a health care institution licensed by the Department as a hospital under A.A.C. Title 9, Chapter 10.
3. "Physician" means any person licensed under provisions of A.R.S. Title 32, Chapter 13 or 17.

Historical Note

Adopted effective September 25, 1991 (Supp. 91-3).

R9-4-102. Pesticide Illness

In Article 2, unless the context otherwise requires:

1. "Case" means any person with an illness which has been determined by a health care professional to be a result of exposure to a pesticide, on the basis of patient history, signs, symptoms or presentation of illness, laboratory findings or results of treatment.
2. "Cluster illnesses" means two or more cases or suspect cases of pesticide illness which are or may be related.
3. "Documented" means supported by written information, such as applicator reports, patient statements, or medical records.
4. "Health care professional" means any physician, hospital intern or resident, surgeon, dentist, osteopath, chiropractor, podiatrist, county medical examiner, nurse or other professional having responsibility for the diagnosis, care or treatment of human illness.
5. "Pest" means any of the following organisms under circumstances that make it deleterious to man or the environment:
   a. Any vertebrate animal other than man;
   b. Any invertebrate animal, including any insect, other arthropod, nematode, or mollusk such as a slug and snail, but excluding any internal parasite of living man or other living animals;
   c. Any plant growing where not wanted, including moss, alga, liverwort, or other plant of any higher order, and any plant part; or
   d. Any fungus, bacterium, virus, or other microorganism, except for those on or in living man or other living animals and those on or in processed food or processed animal feed, beverages, drugs and cosmetics.
6. "Pesticide" means any substance or mixture of substances, including inert ingredients, intended for preventing, destroying, repelling or mitigating any pests, or any substance or mixture of substances intended for use as a plant growth regulator, defoliant or desiccant.
7. "Pesticide illness" means disturbance of function, damage to structure or illness in humans which results from the inhalation, absorption or ingestion of any pesticide.
8. "Poison control centers" means entities in the Arizona poison control network which engage in consultations concerning possible pesticide poisonings.
9. "Suspect case" means any person with a syndrome or signs and symptoms of illness which a health care professional believes, based on professional judgement, may be a result of exposure to one or more pesticides, but which does not meet the definition of case.

Historical Note

Adopted effective August 15, 1989 (Supp. 89-3).
Amended effective April 9, 1993 (Supp. 93-2).

R9-4-103. Definitions: Blood Lead Levels

In Article 3, Blood Lead Levels, unless the context otherwise requires:

1. "Physician" means a person engaged in the practice of medicine and licensed pursuant to A.R.S. Title 32, Chapter 13 or 17.
2. "Whole human blood" means blood taken from any person, alive or dead, which has not been separated into its plasma, erythrocyte, leukocyte and/or thrombocyte components.

Historical Note

Adopted effective August 15, 1989 (Supp. 89-3).
Amended effective March 4, 1993 (Supp. 93-1).

R9-4-104. Definitions, Cancer Registry

In Article 4, unless the context otherwise requires:

1. "Arizona Cancer Registry" (ACR) means the unit of the Department authorized to conduct cancer surveillance.
2. "Cancer clinic" means every health care institution, whether organized for profit or not, which is not a hospital and which provides outpatient cancer diagnosis and treatment of 100 or more cancer cases per year, including outpatient surgical facilities, staff-based health maintenance organizations, multispecialty clinics, and outpatient radiation therapy facilities.
3. "Cancer registry" means a program authorized to receive, collect and maintain information on persons diagnosed with cancer.
4. "Case" means any person with a cancer, or carcinoma in situ, or benign tumor of the central nervous system. This does not include localized skin cancer of the following

types: papillary, squamous cell, basal cell, or carcinoma not otherwise specified.
5. "Date of last contact" means the date the case was last known to be alive.
6. "Doctor" means physician or dentist.
7. "Follow-up report" means a standard ACR-supplied form or a diskette that conveys whether the case is alive or dead, the status of the disease and subsequent treatments received by the case.
8. "Registrar" means a person who has two years of experience working in a cancer registry, or two years of experience in medical record discharge analysis, coding, or abstracting, or who has successfully completed a college-level course in anatomy and physiology, and a course in medical terminology.
9. "Stage" means the categorization of the extent of cancer, using the TNM classification scheme.
10. "TNM" means the **T**umor size, lymph **N**ode involvement, and distant **M**etastases codes and classification scheme promulgated by the American Joint Committee on Cancer, *Manual for Staging of Cancer* (3rd Ed.), J.B. Lippincott Company, East Washington Square, Philadelphia, PA 19105, incorporated herein by reference and on file with the Office of the Secretary of State.
11. "Vital status" means whether the patient is alive or dead.

Historical Note
Adopted effective January 1, 1992, filed September 25, 1991 (Supp. 91-3). "Register" corrected to "Registry" in subsection (1) (Supp. 93-1).

R9-4-105. Definitions, birth defects monitoring program
In Article 5, unless the context otherwise requires:
1. "Arizona Birth Defects Monitoring Program" (ABDMP) means birth defects registry within the Department.
2. "Adverse reproductive outcome" means conditions which individually and collectively represent unsatisfactory pregnancy results, including spontaneous abortions, low birth weight, fetal deaths, birth defects, infant mortality, chromosomal abnormalities, genetic mutations and changes in sex ratios.
3. "Birth defect" means an abnormality of structure, function, or body chemistry, present at or before birth or which may appear later in life.
4. "ICD-9-CM" means the *International Classification of Diseases*, 9th Revision, *Clinical Modification*, Volumes One and Two, U.S. Department of Health and Human Resources, Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, incorporated herein by reference and on file with the Office of the Secretary of State.
5. "Reportable case" means any child from birth to one year of age who has been diagnosed as having a birth defect.
6. "Reporting source" means hospitals, genetic testing facilities and the Department's Children's Rehabilitative Services program.

Historical Note
Adopted effective September 25, 1991 (Supp. 91-3).

ARTICLE 2. PESTICIDE ILLNESS

R9-4-201. Pesticide Illness Reporting Requirements
Any health care professional or poison control center, who participates in the diagnosis of a case of pesticide illness, or determines that an illness may be related to documented exposure to a pesticide, shall file a report of pesticide illness with the Department as follows:
1. Reports of cases and suspect cases of pesticide illness shall be made within five days of the date of determining that an illness is or may be a result of documented exposure to a pesticide, except:
   a. Any case or suspect case which results in hospitalization or death shall be filed immediately or no later than 24 hours from the time of hospital admission or death.
   b. Reports of cluster illnesses shall be filed immediately or no later than 24 hours from the time the second case or suspected case is identified.
2. Reports shall be made by telephone, in person or in writing. The report shall contain:
   a. Patient's name, address and telephone number;
   b. Date of birth;
   c. Race or ethnicity;
   d. Gender;
   e. Occupation;
   f. Dates of onset and diagnosis;
   g. Name of the pesticide if known;
   h. Name, address and telephone number of the person making the report;
   i. The reason for believing the illness is caused by or related to documented exposure to a pesticide.
   j. Statement specifying whether the illness is caused by or related to a documented pesticide exposure.

Historical Note
Adopted effective August 15, 1989 (Supp. 89-3). Amended effective April 9, 1993 (Supp, 93-2).

ARTICLE 3. BLOOD LEAD LEVELS

R9-4-301. Reporting Significant Blood Lead Levels
A. Any physician who finds evidence of lead in whole human blood at or above 10 micrograms of lead per deciliter of whole blood shall file a report of an elevated blood lead level with the Department as follows:
1. Reports shall be made within five days of the date of finding the level to be elevated.
2. Reports shall be by telephone or submitted in writing on forms supplied by the Department.
3. All reports shall include the patient's name, address, telephone number, the date of birth, race or ethnicity, gender, occupation, the level of lead and the date the blood lead level was found to be elevated. The report shall also include the name and address of the laboratory making the determination, and the name, address and telephone number of the person making the report.

B. Clinical laboratory directors or their designated representatives who find evidence of lead in a sample of whole blood at or above 10 micrograms of lead per deciliter of whole blood shall file a report of an elevated blood lead with the Department as follows:
1. Reports shall be made within five working days of the date of finding the level to be elevated.
2. Reports shall be by telephone or submitted in writing on forms supplied by the Department.
3. All reports shall include the patient's name, address, telephone number, the date of birth, race or ethnicity, gender, the name of the patient's physician, the level of lead, and the date the blood lead level was found to be elevated. The report shall also include the name and address of the laboratory making the determination.

Historical Note
Adopted effective August 15, 1989 (Supp. 89-3). Amended effective March 4, 1993 (Supp. 93-1).

ARTICLE 4. CANCER REGISTRY

R9-4-401. Case reporting

A. Case reports shall be submitted to the ACR by cancer clinics, doctors, and hospitals, except for behavioral and rehabilitation hospitals, Clinics seeing fewer than 100 cancer cases per year shall comply as per the requirements for doctors.

B. A case report shall be prepared on a form provided by the ACR and shall use standardized codes and coding format supplied by the ACR in the coding of the data items on the case report.

1. A full case report shall contain narrative and coded data that includes patient identification, demographic and diagnostic information, a chronological summary of the disease, stage, extent of disease, treatment, recurrence, vital status, names of doctors, reporting registrar and facility.
2. An abbreviated case report shall contain patient identification, demographic and diagnostic information, vital status and the names of the doctors.

C. Each year following the date of last contact, hospitals shall submit a follow-up report of each case to the ACR. Upon request of hospitals or the ACR, cancer clinics and doctors shall provide information available in office records for the follow-up report.

Historical Note
Adopted effective January 1, 1992, filed September 25, 1991 (Supp. 91-3).

R9-4-402. Filing requirements

A. A hospital with 50 or more licensed beds shall appoint one or more cancer registrars who shall complete and submit a full case report for each case, whether inpatient or outpatient, diagnosed or admitted for the first time. The case report shall be submitted within 180 days from the date the case is discharged.

B. A hospital with less than 50 licensed beds shall either report as specified in subsection (A) or shall permit the staff of the ACR access to, and review of, the medical records of all patients with cancer for the purpose of completing a case report form. If the latter method of reporting is employed, the hospital shall provide the medical records for review every six months.

C. Cancer clinics shall submit an abbreviated case report to the ACR for each cancer case not immediately referred to a hospital. They shall designate a doctor or a registrar to submit the case report, if required, within 90 days of diagnosis or initiation of treatment at the facility.

D. Doctors shall utilize one of the following procedures to submit an abbreviated case report of any cancer case they diagnose but do not immediately refer for cancer treatment to a hospital or to a cancer clinic.

1. If a doctor receives a report form from the ACR, the doctor shall review the form, verify its accuracy, correct or complete any missing information, and resubmit it to the ACR within 30 days; or
2. If a doctor diagnoses cancer in an outpatient case without a record in a pathology laboratory licensed by the Department, the doctor shall initiate an abbreviated case report and submit it directly to the ACR within 30 days.

E. Within two years of the effective date of these rules, registrars at hospitals with 150 or more licensed beds, and cancer clinics submitting 100 or more case reports per year shall submit a paper copy of the case report and an IBM compatible 5 1/4 or 3 1/2 inch diskette that contains computer-readable data coded in accordance with R9-4-401. Diskettes from hospitals shall be submitted monthly. Diskettes from cancer clinics shall be submitted quarterly.

Historical Note
Adopted effective January 1, 1992, filed September 25, 1991 (Supp. 91-3).

R9-4-403. Data quality assurance

A. Upon notice of five business days in advance, records maintained by hospitals, cancer clinics and doctors shall be subject to review by the staff of the ACR to assure completeness and accuracy of the data reported.

B. Upon request by the ACR, hospital registrars shall abstract a standard medical record for the purpose of demonstrating the variability with which data is reported.

C. Reports not prepared in accordance with R9-4-401(B) shall be returned to the reporting entity for revision and resubmitted to the ACR within 15 days of date of receipt.

D. A hospital, cancer clinic or doctor shall satisfy the requirement for complete reporting of cases when 97% of the reportable cases in a calendar year are submitted to the ACR. The Department shall review the medical records to determine whether there has been compliance with this requirement.

E. Each hospital shall submit follow-up reports covering 90% of the total number of cases reported by that institution.

Historical Note
Adopted effective January 1, 1992, filed September 25, 1991 (Supp. 91-3).

R9-4-404. Effective date

The rules in this Article and the related definitions in R9-4-104 shall take effect on January 1, 1992.

Historical Note
Adopted effective January 1, 1992, filed September 25, 1991 (Supp. 91-3).

ARTICLE 5. BIRTH DEFECTS MONITORING PROGRAM

R9-4-501. Procedures; access to medical records

A. Reporting sources with patients up to one year of age who have been diagnosed as having a birth defect shall allow the ABDMP to access and to extract personal identifiers, demographic, and diagnostic data from the following:

1. Disease indices,
2. Intensive care unit logs,
3. Labor and delivery logs,
4. Pathology-autopsy logs (for stillbirths),
5. Patient records,
6. Pediatric admission and discharge date,
7. Ultrasound logs, and
8. Reports pertaining to chromosomal analysis and tests for detection of hereditary biochemical disorders.

B. Access to the medical records by ABDMP shall be allowed once every six months for hospitals with fewer than 2000 births per year and once every three months for hospitals with 2000 or more births per year.

C. The disease indices that hospitals are to make accessible to the ABDMP shall list, in ascending order, each ICD-9-CM diagnosis code and shall indicate whether the code reflects the primary or secondary diagnosis, the age of the patient, the dates of admission and discharge, and each patient's medical record number.

Historical Note
Adopted effective September 25, 1991 (Supp. 91-3).

TITLE 9. HEALTH SERVICES

CHAPTER 5. DEPARTMENT OF HEALTH SERVICES CHILD CARE FACILITIES

Chapter 5 consisting of Sections R9-5-101, R9-5-201 through R9-5-211, R9-5-301 through R9-5-308, R9-5-401 through R9-5-404, R9-5-501 through R9-5-222, R9-5-601 through R9-5-614 adopted effective December 12, 1986.

Former Chapter 5 consisting of Sections R9-5-110 through R9-5-113, R9-5-211 through R9-5-218, R9-5-311 through R9-5-313, R9-5-411 through R9-5-425 repealed effective December 12, 1986.

Heading of Chapter permanently changed from "Department of Health Services - Day Care Centers" to "Department of Health Services - Child Care Facilities" effective October 4, 1990 (Supp. 90-4).

Heading of Chapter changed by emergency action from "Department of Health Services - Day Care Centers" to "Department of Health Services - Child Care Facilities" effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3).

ARTICLE 1. DEFINITIONS

Section
R9-5-101. Definitions

ARTICLE 2. FACILITY LICENSURE

Article 2 consisting of Sections R9-5-201 through R9-5-211 repealed; new Sections R9-5-201 through R9-5-209 adopted; and Article heading amended effective October 17, 1997 (Supp. 97-4).

Section
R9-5-201. Application for a License
R9-5-202. Initial License Application Time-frames
R9-5-203. Registration and Fingerprinting Requirements
R9-5-204. Revocation, Denial, or Reconsideration of Registration
R9-5-205. Child Care Services Classifications
R9-5-206. License Renewal
R9-5-207. Changes Affecting License
R9-5-208. Inspections; Investigations
R9-5-209. Denial, Revocation, or Suspension of License
R9-5-210. Repealed
R9-5-211. Repealed

ARTICLE 3. FACILITY ADMINISTRATION

Article 3 consisting of Sections R9-5-301 through R9-5-308 repealed; new Sections R9-5-301 through R9-5-309 adopted; and Article heading amended effective October 17, 1997 (Supp. 97-4).

Section
R9-5-301. General Licensee Responsibilities
R9-5-302. Statement of Child Care Services
R9-5-303. Posting of Notices
R9-5-304. Enrollment of Children
R9-5-305. Child Immunization Requirements
R9-5-306. Admission and Release of Children; Attendance Records
R9-5-307. Suspected or Alleged Child Abuse or Neglect
R9-5-308. Insurance Requirements
R9-5-309. Sanitation, Gas, and Fire Inspections

ARTICLE 4. FACILITY STAFF

Article 4 consisting of Sections R9-5-401 through R9-5-404 repealed; new Sections R9-5-401 through R9-5-404 adopted; and Article heading amended effective October 17, 1997 (Supp. 97-4).

Section
R9-5-401. Staff Qualifications
R9-5-402. Staff Records and Reports
R9-5-403. Training Requirements
R9-5-404. Staff-to-children Ratios

ARTICLE 5. FACILITY PROGRAM AND EQUIPMENT

Chapter 5 consisting of Sections R9-5-501 through R9-5-222 repealed; new Sections R9-5-501 through R9-5-518 and Table 1 adopted; and heading amended effective October 17, 1997 (Supp. 97-4).

Section
R9-5-501. General Child Care Program and Equipment Standards
R9-5-502. Supplemental Standards for Infants
R9-5-503. Standards for Diaper Changing
R9-5-504. Supplemental Standards for 1-year-old and 2-year-old Children
R9-5-505. Supplemental Standards for 3-year-old, 4-year-old, and 5-year-old Children
R9-5-506. Supplemental Standards for School-age Children
R9-5-507. Supplemental Standards for Children with Special Needs
R9-5-508. General Nutrition Standards
R9-5-509. General Food Service and Food Handling Standards
R9-5-510. Discipline and Guidance
R9-5-511. Sleeping Materials and Equipment
R9-5-512. Cleaning and Sanitation
R9-5-513. Pets and Animals
R9-5-514. Accident and Emergency Procedures
R9-5-515. Illness and Infestation
R9-5-516. Medications
R9-5-517. Transportation
R9-5-518. Field Trips
R9-5-519. Repealed
R9-5-520. Repealed
R9-5-521. Repealed
R9-5-522. Repealed
Table 1. Meal Pattern Requirements for Children

ARTICLE 6. PHYSICAL PLANT OF A FACILITY

Article 6 consisting of Sections R9-5-601 through R9-5-614 repealed; new Sections R9-5-601 through R9-5-607 adopted; and Article heading amended effective October 17, 1997 (Supp. 97-4).

Section
R9-5-601. General Physical Plant Standards
R9-5-602. Supplemental Physical Plant Standards
R9-5-603. Facility Square Footage Requirements
R9-5-604. Outdoor Activity Areas
R9-5-605. Swimming Pools
R9-5-606. Fire and Safety
R9-5-607. Required Physical Plant Documents
R9-5-608. Repealed
R9-5-609. Repealed
R9-5-610. Repealed
R9-5-611. Repealed

R9-5-612. Repealed
R9-5-613. Repealed
R9-5-614. Repealed

ARTICLE 7. CERTIFICATION OF DAY CARE GROUP HOMES

Section
R9-5-701. Initial certification
R9-5-702. Certificate to operate a child care group home
R9-5-703. Denial of certification
R9-5-704. Renewal of certification
R9-5-705. Suspension or revocation of certification
R9-5-706. Notice of changes
R9-5-707. Complaints; investigations

ARTICLE 8. DAY CARE GROUP HOME ADMINISTRATION

Section
R9-5-801. Provider standards and responsibilities
R9-5-802. Personnel standards and responsibilities
R9-5-803. Facility staffing
R9-5-804. Inspection reports
R9-5-805. Personnel records and reports
R9-5-806. Children's records and reports
R9-5-807. Attendance records; admission and release of children
R9-5-808. Insurance
R9-5-809. Other businesses on facility premises

ARTICLE 9. PROGRAM AND EQUIPMENT FOR DAY CARE GROUP HOMES

Section
R9-5-901. General program and equipment standards
R9-5-902. Supplemental program and equipment standards for infants and children two years of age and younger
R9-5-903. Supplemental equipment standards for school-age children
R9-5-904. Supplemental program and equipment standards for special needs children
R9-5-905. Supplemental program and equipment standards for night care
R9-5-906. Illness and infestation
R9-5-907. Emergency medical care
R9-5-908. Medications
R9-5-909. Discipline and guidance
R9-5-910. Nutrition and meals
R9-5-911. General food service and food handling standards
R9-5-912. Transportation of children and field trips

ARTICLE 10. ACTIVITY AREAS AND PHYSICAL FACILITY STANDARDS FOR DAY CARE GROUP HOMES

Section
R9-5-1001. Day care group home activity areas
R9-5-1002. Swimming pools
R9-5-1003. Fire and safety
R9-5-1004. Sanitation
R9-5-1005. Diaper changing
R9-5-1006. Pets and animals kept on the premises

ARTICLE 1. DEFINITIONS

R9-5-101. Definitions

In this Chapter, unless otherwise specified, the following terms mean:

1. "Abuse" means the infliction or allowing of physical injury, impairment of bodily function or disfigurement, or the infliction of or allowing another individual to cause serious emotional damage as evidenced by severe anxiety, depression, withdrawal or untoward aggressive behavior, and which emotional damage is diagnosed by a medical doctor or psychologist as prescribed by A.R.S. § 8-223 and which is caused by the acts or omissions of an individual having care, custody, and control of a child. Abuse includes the offenses stated in A.R.S. § 8-546(A)(2).
2. "Accident" means an unexpected occurrence that may or may not be an emergency that causes physical injury to a child and requires attention by a staff member.
3. "Accredited" means approved by the:
   a. New England Association of Schools and Colleges,
   b. Middle States Association of Colleges and Secondary Schools,
   c. North Central Association of Colleges and Schools,
   d. Northwest Association of Schools and Colleges,
   e. Southern Association of Colleges and Schools, or
   f. Western Association of Schools and Colleges.
4. "Activity" means an action planned by a licensee and performed by a child while supervised by a staff member.
5. "Activity area" means a specific indoor or outdoor space or room of a licensed facility that is designated by a licensee for use by enrolled children for activities.
6. "Adaptive device" means equipment used to augment an individual's use of arms, legs, sight, hearing, or other physical part or function.
7. "Age-appropriate" means consistent with a child's age and age-related stage of physical growth and mental development.
8. "Applicant" means:
   a. The following persons requesting an initial or renewal license:
      i. If an individual, the individual owning the facility;
      ii. If a corporation, any 2 officers of the corporation;
      iii. If an association or cooperative, any 2 members of the governing board of the association or cooperative;
      iv. If a limited liability company, the designated manager, or if no manager is designated, any 2 members of the limited liability company;
      v. If a partnership, any 2 of the partners;
      vi. If a joint venture, any 2 individuals signing the joint venture agreement;
      vii. If a public school, any individual designated in writing as signatory for the facility by the school governing board or school district superintendent;
      viii. If a charter school, the person approved to operate a charter school in Arizona by the Arizona Board of Education, Arizona Board of Charter Schools, or a school governing board; or
      ix. If a governmental agency, the director of the governmental agency or the individual designated in writing by the director; or
   b. A licensee submitting a request for a modification to the physical plant of a licensed facility.
9. "Application" means the documents required by the Department for licensure or registration.
10. "Assistant teacher-caregiver" means a staff member who, for compensation, aids a teacher-caregiver in planning, developing, or conducting child care activities.
11. "Association or cooperative" means a group of individuals other than a corporation, limited liability company, partnership, joint venture, or public school who have established a governing board and bylaws to operate a facility.
12. "Calendar week" means a 7-day period beginning Sunday and ending on Saturday.
13. "C.C.P." means Certified Childcare Professional, a credential awarded by the National Child Care Association to individuals successfully completing a test of ability to work effectively with children.
14. "C.D.A." means Child Development Associate, a credential awarded by the Child Development Associate National Credentialling Program to individuals successfully completing a test of ability to work effectively with children.
15. "Change in ownership" means a transfer of controlling legal or controlling equitable interest and authority in a facility resulting from a sale or merger of a facility.
16. "Child" has the same meaning as in A.R.S. § 36-881(1).
17. "Child care" has the same meaning as in A.R.S. § 36-881(2).
18. "Child care experience" means written documentation of work with children in:
   a. A child care facility or group home that is licensed, certified, or approved by a state in the United States;
   b. A public or private school, or an accommodation school as defined in A.R.S. § 15-101(1); or
   c. The professional fields of nursing, social work, psychology, child development, or closely related field.
19. "Child care services" means the range of activities and programs provided by a licensee to a child, including personal care, supervision, education, guidance, and transportation.
20. "Child Protective Services" means the Child Protective Services Program, Arizona Department of Economic Security.
21. "Child with special needs" means a child with:
   a. A health care provider's diagnosis and record of a physical or mental condition that substantially limits the child in providing self-care or performing age-appropriate manual tasks or any other major life function such as walking, seeing, hearing, speaking, breathing, or learning;
   b. A developmental disability as defined in A.R.S. § 36-551; or
   c. At least 1 of the developmental disabilities listed in A.R.S. § 15-761 and who requires special education as defined in A.R.S. § 15-761.
22. "Clean" means to remove dirt or debris by such methods as washing with soap and water, vacuuming, wiping, dusting, or sweeping.
23. "Closely related field" means any educational instruction or occupational experience pertaining to the growth, development, physical or mental care, or education of children.
24. "Communicable disease" has the same meaning as in A.A.C. R9-6-101(5).

25. "Compensation" means money or other consideration, including goods, services, vouchers, time, or other benefit, that is received by a licensee from any individual as payment for child care services or that is paid to a staff member by a licensee.
26. "Corporal punishment" means any physical action that inflicts pain to the body of a child, including but not limited to: shaking, spanking, punching, hitting, pinching, biting, pushing, slapping, twisting, jerking, kicking, pulling hair or strangling a child; or any act which may result in an abrasion, bruise, welt, contusion, laceration, burn, wound, cut, puncture, internal injury, fracture, sprain or dislocation, or a subdural hemorrhage or hematoma.
27. "C.P.C." means Certified Professional in Childcare, a credential awarded by the National Early Care and Education Association to individuals successfully completing a test of ability to work effectively with children.
28. "CPR" means cardiopulmonary resuscitation.
29. "Credit hour" means an earned academic unit of study based on attending a 1-hour class session per calendar week at an accredited college or university.
30. "Days" means calendar days.
31. "Developmentally appropriate" means consistent with a child's physical, emotional, social, cultural, and cognitive development, based on the child's age and family background and the individual child's pattern and timing of growth, personality, and learning style.
32. "Discipline" means to provide correction of a child's behavior that does not meet generally accepted levels of social behavior.
33. "Emergency" means a potentially life-threatening occurrence involving a child or staff member that requires an immediate response or medical treatment.
34. "Endanger" means to expose a child to a situation where physical or mental injury to the child may occur.
35. "Enrolled" means a child has been placed by a parent and accepted by a licensee for child care services.
36. "Facility" means child care facility as defined in A.R.S. § 36-881(3).
37. "Facility director" means an individual meeting the qualifications in R9-5-401(1) who is designated by a licensee as the individual responsible for the daily on-site operation of a facility.
38. "Facility premises" means property that is:
    a. Designated on an application for a license by the applicant, and
    b. Licensed for child care services by the Department under A.R.S. § 36-881 *et seq.* and these rules.
39. "Field trip" means an activity planned by child care personnel for:
    a. Preschool children off facility premises, or
    b. School-age children off facility premises or school campus.
40. "Final construction drawings" means facility plans approved by local government for the construction or modification of a facility that include the architectural, structural, mechanical, electrical, fire protection, plumbing, and technical specifications of the physical plant and the facility premises.
41. "Food preparation" or "preparing food" means handling, washing, cutting, mixing, spreading, combining ingredients, and cooking foods using a utensil as defined in A.A.C. R9-8-112(35) but does not include:
    a. Using single-service articles as defined in A.A.C. R9-8-112(30),
    b. Handling or distributing whole fruits or vegetables,
    c. Distributing prepackaged foods, or
    d. Combining whole uncooked foods.
42. "Guidance" means the ongoing direction, counseling, teaching, or modeling of accepted social behavior through which a child learns to develop and maintain the self control, self reliance, and self esteem necessary to assume responsibilities, make daily living decisions, and live according to generally accepted social behavior.
43. "Hazard" means a source of endangerment.
44. "Health care provider" means a state board licensed, registered or certified physician, physician's assistant, nurse, nurse practitioner, psychologist, or occupational, physical or respiratory therapist.
45. "High school equivalency diploma" means the document issued by the Arizona Department of Education under A.R.S. § 15-702 or by another state, to an individual who passes a general educational development test.
46. "Hours of operation" means the specific time during a day for which a licensee is licensed to provide child care services.
47. "Illness" means physical manifestation or signs of any sickness or communicable disease such as pain, vomiting, rash, fever, discharge, or diarrhea.
48. "Infant" means a child 12 months of age or younger or a child 18 months of age or younger who is not yet walking.
49. "Infestation" means the presence of lice, pinworms, scabies, or other parasites.
50. "Inspection" means on-site examination of a facility by the Department to determine compliance with A.R.S. § 36-881 *et seq.* and these rules, an on-site review of facility records or reports by the Department or on-site examination of a facility by local jurisdictions.
51. "Lesson plan" means a written description of the activities scheduled in each activity area for a day.
52. "License" means the written authorization issued by the Department to operate a facility in Arizona.
53. "Licensed capacity" means the maximum number of children for whom a licensee is licensed by the Department to provide child care services.
54. "Licensee" means a person as defined by A.R.S. § 36-881(6) to whom the Department issues a license to operate a facility in Arizona.
55. "Local" means under the jurisdiction of a city or county in Arizona.
56. "Mat" means a foam pad that has a waterproof cover and is of sufficient size and thickness to accommodate the height, width, and weight of a reclining child's body.
57. "Medication" means a substance prescribed by a physician or available over-the-counter for the treatment of illness.
58. "Menu" means a written description of food provided by a facility and served as a meal or snack.
59. "Modification" means an alteration or addition to the physical plant of a licensed facility that requires a permit issued by local government.
60. "Motor vehicle" has the same meaning as defined in A.R.S. § 28-101(28).
61. "N.A.C." means the National Administrator Credential, an award issued by the National Child Care Association to an individual successfully completing a test of ability to work effectively with children as a director of a child care facility.
62. "Naptime" means any time during hours of operation, other than evening and nighttime hours specified in R9-5-

205, that is designated by a licensee for the rest or sleep of children.

63. "Neglect" has the same meaning as in A.R.S. § 8-546(A)(7).
64. "One-year-old" means a child 12 months of age or older who is not yet 2 years of age.
65. "Parent" means a natural, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction.
66. "Perishable food" means food which becomes unfit for human consumption if not stored to prevent spoilage.
67. "Physical plant" means a building that houses a facility, or licensed areas within a building, including the architectural, structural, mechanical, electrical, plumbing, and fire protection elements of the building.
68. "Physician" means a doctor currently licensed to practice allopathic or osteopathic medicine in any state of the United States.
69. "Private pool" has the same meaning as in A.A.C. R9-8-811(J).
70. "Private school" has the same meaning as in A.R.S. § 15-101(16).
71. "Program" means a variety of activities organized and conducted by a staff member.
72. "Public pool" has the same meaning as in A.A.C. R9-8-811(K).
73. "Public school" means school as defined in A.R.S. § 15-101(3) and (17).
74. "Registration" means approval by the Department to operate or work in a child care facility after an individual's completion of the fingerprinting process required by the Department.
75. "Regular basis" means child care services are offered at a facility at recurring, fixed, or uniform intervals.
76. "Resident" means an individual who does not provide child care but who is present in a facility for more than 30 consecutive days.
77. "Sanitize" means to use heat, chemical agents, or germicidal solutions to disinfect and reduce pathogen counts, including bacteria, viruses, mold, and fungi.
78. "School-age child" means a child who is 5 years of age or older before beginning the current school year in a public or private school.
79. "School campus" means the contiguous grounds of a public or private school including the buildings, structures, and outdoor areas available for use by children attending the school.
80. "School governing board" means governing board as defined in A.R.S. § 15-101(8).
81. "Semi-public pool" has the same meaning as in A.A.C. R9-8-811(N).
82. "Service classification" means 1 of the classifications specified in R9-5-205.
83. "Signed" means having affixed an individual's name consistent with customary usage on an official document or a symbol of the name if the individual is unable to write.
84. "Space utilization" means the designated use of an area within a facility for specific child care services or activities.
85. "Staff", or "staff member", or "child care personnel" means any employee or volunteer working at a child care facility.
86. "STRIVE" means Students Together Rising in Vocational Education, a vocational organization authorized by the Arizona Department of Education under A.R.S. § 15-781.01.
87. "Student-aide" means an individual 15 years of age or younger enrolled in an educational, curriculum-based course of study who, without being compensated by a licensee, is present at a facility to receive instruction from and supervision by child care personnel in the provision of child care services.
88. "Substantive review" means the Department's process for determining whether an applicant for a license and an applicant's facility meet the requirements of A.R.S. § 36-881 *et seq*. and these rules, including an evaluation of the completed documents submitted as prescribed by R9-5-201 and R9-5-203(A) and inspection of the facility.
89. "Supervision" means:
    a. The physical presence of a facility director or staff member who has responsibility for and is within sight and sound of an enrolled child, or
    b. The physical presence of a facility director or teacher-caregiver who is providing direction to a staff member or student-aide.
90. "Swimming pool" has the same meaning as in A.A.C. R9-8-811(P).
91. "Teacher-caregiver" means a staff member responsible for developing, planning, and conducting child care activities.
92. "Training" means child care-related conferences, seminars, lectures, workshops, classes, courses, or instruction required by the Department of a licensee or child care personnel.
93. "Volunteer" means a staff member who works in a facility without compensation by the facility.

Historical Note

Adopted effective December 12, 1986 (Supp. 86-6). Amended by adding a new paragraph (16) and renumbering accordingly effective July 7, 1988 (Supp. 88-3). Amended as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency amendments readopted and amended effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency amendments readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency expired. Emergency amendments readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency amendments readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency amendments permanently adopted with changes effective October 4, 1990 (Supp. 90-4). Amended effective October 17, 1997 (Supp. 97-4).

ARTICLE 2. FACILITY LICENSURE

R9-5-201. Application for a License

A. An applicant for a license shall:
1. Be 18 years of age or older;
2. Submit the following completed documents to the Department:
    a. A notarized application signed by the applicant stating:
        i. The applicant's name;
        ii. The facility's name, street address, mailing address, and telephone number; and
        iii. The name and type of organization applying for a license;
    b. Organization information including:

i. Address of organization;
ii. Name, title, and address of the organization's statutory agent or individual designated by the organization to accept service of process and subpoenas;
iii. Name and title of each officer and board member, if applicable; and
iv. Copies of Articles of Incorporation, partnership or joint venture documents, or limited liability documents, if applicable;

c. Registration documents as prescribed in R9-5-203;
d. The physical plant documents required by R9-5-607 that include the service classifications being requested by the applicant;
e. An agricultural attachment that contains the information required by A.R.S. § 36-882 (B); and
f. The fee required by A.R.S. § 36-882 (F);

3. Before the issuance of a license, submit written documentation verifying that the applicant or a registered individual designated by the applicant has completed not less than 4 actual hours of Department-provided training that includes the Department's role in licensing and regulating child care facilities under A.R.S. § 36-881 *et seq*. and these rules; and
4. Demonstrate compliance with A.R.S. § 36-881 *et seq.* and these rules through a facility inspection by the Department.

B. A person shall apply for a license as prescribed by this Section for:
1. Each facility operated by the same person at different locations, and
2. Each facility operated by different persons at the same location.

C. The Department does not require an application for a supplementary structure on grounds contiguous to a facility, under the same ownership, and intended to be used in conjunction with a facility.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-202. Initial License Application Time-Frames

A. For an initial license, the overall time-frame described in A.R.S. § 41-1072 (2) is 90 days.

B. For an initial license, the administrative completeness review time-frame described in A.R.S. § 41-1072(1) is 30 days and begins on the date the Department receives an application.
1. If any of the application documents are missing or if information on the submitted documents is deficient, the Department shall send to the applicant, by certified mail with return receipt, a written notice that states each deficiency and information and document needed to complete the application. The 30 day time-frame for the Department to finish the administrative completeness review is suspended from the date the Department mails the deficiency notice to the applicant until the date the Department receives the deficient information or missing document.
2. If all of the documents are submitted and the information on the documents is complete, the Department shall send a written notice of administrative completeness to the applicant.
3. If the documents or information are not submitted within 180 days from the date of notice of incompleteness, the Department shall consider the application withdrawn.

C. For an initial license, the substantive review time-frame described in A.R.S. § 41-1072(3) is 60 days and begins on the date the Department sends written notice of administrative completeness to the applicant.
1. As part of the substantive review, the Department may schedule an inspection which may require more than 1 visit to the facility.
2. If an applicant or facility does not meet the requirements of A.R.S. § 36-881 *et seq*. and these rules, the Department shall provide to the applicant a written notice of nonconformance that states each statute and rule upon which nonconformance is based.
   a. Within 120 days from the date of receipt of a written notice of nonconformance the applicant shall submit, to the Department, written documentation of the corrections required in the notice of nonconformance. The 60 day time-frame for the Department to finish the substantive review is suspended from the date the Department provides the written notice of nonconformance to the applicant until the Department receives documentation of corrections.
   b. The Department shall issue a written notice of denial of license as prescribed in A.R.S. §§ 36-888 and 41-1076, if:
      i. The applicant does not submit documentation of corrections within the time-frame in subsection (C)(2)(a); or
      ii. Upon receipt of documentation of corrections from the applicant, the Department determines that the applicant or facility do not meet the requirements of A.R.S. § 36-881 *et seq.* and these rules.
3. If the applicant and facility meet the requirements of A.R.S. § 36-881 *et seq.* and these rules, the Department shall issue a license to the applicant.

D. If a time-frame's last day falls on a Saturday, Sunday, or a legal holiday, the next business day will be considered the time-frame's last day.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-203. Registration and Fingerprinting Requirements

A. An applicant for a license shall apply for registration with the Department by submitting:
1. Unless exempted by A.R.S. § 36-883.02, a completed and legible fingerprint card;
2. A registration to work form, provided by the Department, completed and signed by the applicant, and notarized that contains:
   a. The applicant's name, birth date, social security number, home address, telephone number, and job title;
   b. If previously registered with the Department, the date of previous registration and name used for registration;
   c. The facility name, address, telephone number;
   d. An identification of whether the applicant is awaiting trial on, has been convicted of, or has admitted in open court or as prescribed by a plea agreement committing any criminal offense described in A.R.S. § 36-883.02(G);
   e. Certification that the applicant is not a parent of a child who has been adjudicated dependent as prescribed by A.R.S. § 8-201(11); and

f. Certification that the applicant has not had a license to operate a facility denied or revoked in any state; and

3. A registration recap form provided by the Department, completed by the applicant for licensure or licensee, which contains the:
   a. Name, address, and telephone number of the facility;
   b. Name of facility director; and
   c. Name of each individual applying for registration.

B. Within 20 days from the date of employment or volunteer service of each staff member, a licensee shall submit the information in subsection (A) for each staff member who is 18 years of age or older.

C. Within 30 days of receipt of an application for registration, the Department shall return to the applicant or licensee a copy of the registration recap form with verification of the Department's receipt. The individuals listed on the verified registration recap form are registered with the Department to work in the child care facility listed on the recap form until the Department denies or revokes the registration.

D. A registered licensee or staff member who has had an uninterrupted association with or continuous employment in a licensed facility which changes ownership, shall submit the documents in subsections (A)(2) and (A)(3) to the Department within 20 days from the date of ownership change.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-204. Denial, Revocation, or Reconsideration of Registration

A. The Department shall deny or revoke the registration of an individual:
1. Who is awaiting trial on, has been convicted of, or has admitted in open court or as prescribed by a plea agreement, committing any criminal offense listed in A.R.S. § 36-883.02(G) except as provided in A.R.S. § 36-883.02 (L); or
2. Whose presence in a facility may have a detrimental effect on the health, safety, or welfare of children based on evidence obtained from:
   a. A law enforcement agency;
   b. Any criminal, civil, or official proceeding of record;
   c. A written psychological evaluation or professional opinion of:
      i. A physician licensed by a state board of medical examiners;
      ii. A psychologist licensed by a state board of psychologist examiners;
      iii. A behavioral health professional certified by the Arizona board of behavioral health examiners or the equivalent agency from another state; or
      iv. A social worker, therapist, or counselor certified or licensed by a state board or by a professional accrediting organization or agency for these professions; or
   d. Child Protective Services.

B. If the Department has determined an individual may have a detrimental effect on the health, safety, or welfare of children or an individual has committed 1 of the offenses listed in A.R.S. § 36-883.02(G), not subject to A.R.S. § 36-883.02(L), the Department shall send a written notice of denial or revocation of registration to the:
1. Individual, by certified mail with return receipt, that states:
   a. The reason for the denial or revocation of registration, and
   b. The individual's right to a hearing by the Department if requested in writing within 30 days from the receipt of the Department's notice.
2. Licensee or applicant for licensure within 5 days of the individual's receipt of the notice required in subsection (B)(1).

C. If an individual has committed 1 of the offenses in A.R.S. § 36-883.02(L), the Department shall determine whether the individual is a recidivist. An individual is not a recidivist if the individual meets the following requirements:
1. If the offense was a felony, 5 years or more have passed between the conviction of the offense and the date the individual submitted a complete application for registration and the individual is not awaiting trial on, has not been convicted of, or has not admitted in open court or as prescribed by a plea agreement, committing any felony within the last 5 years or any misdemeanor within the last 2 years; or
2. If the offense was a misdemeanor, 2 years or more have passed between the conviction of the offense and the date the individual submitted a complete application for registration and the individual is not awaiting trial on, has not been convicted of, or has not admitted in open court or as prescribed by a plea agreement, committing any felony within the last 5 years or any misdemeanor within the last 2 years.

D. If an individual does not meet the requirements of subsection (C), the Department shall send a written notice of denial or revocation to the:
1. Individual, by certified mail with return receipt, that states:
   a. The reason for the denial or revocation of registration, and
   b. The individual's right to a hearing by the Department if requested in writing within 30 days from the receipt of the Department's notice.
2. Licensee or applicant for licensure within 5 days of the individual's receipt of the notice required in subsection (B)(1).

E. If an individual meets the requirements of subsection (C), the Department shall send to the individual, by certified mail with return receipt, a written notice of intent to deny the registration. The notice shall state:
1. The criminal offense that was disclosed by the fingerprint check; and
2. The Department's process for reconsideration of the registration denial.

F. Within 30 days from the date of receipt of a notice of intent to deny a registration, an individual may submit a request for reconsideration to the Department that contains the individual's name, address, and telephone number and written documentation that demonstrates the individual is rehabilitated including:
1. Employment history of at least 6 months of continuous employment, with no more than 7 consecutive days break in employment within 2 years before the date of receipt of a completed application, including the name, address, and telephone number of each employer or educational history that shows the completion of at least 2 consecutive semesters at a postsecondary education institution within 2 years before the date of receipt of a completed applica-

tion, including the dates of enrollment and completion of course work;
2. Two written references from individuals, 18 years of age or older and not related by blood or marriage to the individual, who have known the individual for at least 6 months before the date of receipt of a completed application;
3. An explanation of why the individual believes the individual has been rehabilitated;
4. Any other documentation which the individual believes supports the individual's claim of being rehabilitated; and
5. A copy of any court record, such as conviction notice, plea bargain agreement, presentence investigation, minute entry, probation termination or completion document, or any expungement or pardon record that pertains to each crime for which the individual has been convicted. If the individual is unable to provide court documents for each conviction, the individual shall provide written documentation from the court having jurisdiction stating the reason the records are unavailable.

G. Within 30 days from the date of receipt of the written documentation required by subsection (F), the Department shall determine whether the individual meets the requirements in subsection (F). If the individual meets the requirements, the Department shall send a written notice of registration to the individual. If the individual does not meet the requirements, the Department shall deny the registration following the requirements in subsection (B).

H. If an individual does not request a reconsideration within 30 days from the date of receipt of the notice of intent to deny, the Department shall, by certified mail with return receipt, issue a notice of denial containing the information in subsection (B).

I. An individual who has been denied registration as prescribed in subsection (G) or (H) shall not submit an application for registration until 12 months has elapsed from the date of the notice of registration denial. The Department shall return an application for registration to an individual who has been denied registration as prescribed in subsection (G) or (H) if the application is submitted less than 12 months from the date of the notice of registration denial.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-205. Child Care Services Classifications

A. When conducting a substantive review, the Department shall determine whether the licensee meets the licensure requirements of A.R.S. § 36-881 *et seq.* and these rules to provide child care services on a regular basis in 1 or more of the following classifications.
1. Full-day care: Child care services provided for 6 or more hours per day between the hours of 5 a.m. and 8 p.m.
2. Part-day care: Child care services provided for less than 6 hours per day between the hours of 5 a.m. and 8 p.m.
3. Evening and nighttime care: Child care services provided between the hours of 8 p.m. and 5 a.m.
4. Infant care: Child care services provided to an infant as defined in R9-5-101(48).
5. One-year-old child care: Child care services provided to a 1-year-old child as defined in R9-5-101(64).
6. School-age child care: Child care services provided to a school-age child as defined in R9-5-101(78).

B. The Department shall designate, on a facility's license, the classifications of child care services the facility is licensed to provide.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-206. License Renewal

A. At least 45 days before the expiration date of a current license, an applicant for renewal of a license shall submit to the Department:
1. A complete, signed, and notarized application that includes:
   a. The applicant's name;
   b. The facility's name, street address, mailing address, and telephone number; and
   c. The name and type of organization applying for license renewal;
2. Any changes to the organization information previously submitted as prescribed in R9-5-201(A)(2)(b); and
3. The fee required by A.R.S. § 36-882(F).

B. For a renewal license, the overall time-frame described in A.R.S. § 41-1072(2) is 45 days.

C. For a renewal license, the administrative completeness review time-frame described in A.R.S. § 41-1072(1) is 15 days and begins on the date the Department receives the renewal application.
1. If the submitted documents are deficient, the Department shall send to the applicant, by certified mail with return receipt, the submitted documents and a deficiency notice.
   a. The notice shall:
      i. State each deficiency and the information needed to complete the documents; and
      ii. Advise the applicant that an additional $50 late filing fee is due if a complete renewal application is not received by the Department at least 45 days before the expiration date of the current license.
   b. The 15 day time-frame for the Department to finish the administrative completeness review is suspended from the date the Department mails the deficiency notice to the applicant until the date the Department receives the information.
   c. If an applicant does not submit a complete renewal application before the expiration date of the current license, the license shall expire.
2. If the submitted documents are complete:
   a. The Department shall send a written notice of administrative completeness to the applicant; and
   b. The current license shall not expire until the Department issues the renewal license or written notice of denial.

D. For a renewal license, the substantive review time-frame described in A.R.S. § 41-1072(3) is 30 days and begins on the date the Department sends written notice of administrative completeness to the applicant.
1. If an applicant or facility does not meet the requirements of A.R.S. § 36-881 *et seq.* and these rules, the Department shall provide to the applicant a written notice of nonconformance that states each statute and rule upon which nonconformance is based.
   a. Within 10 days from the date of receipt of a written notice of nonconformance the applicant shall submit, to the Department, written documentation of the corrections required in the notice of nonconformance. The 30 day time-frame for the Department to finish the substantive review is suspended from the date the Department provides the written notice of

nonconformance to the applicant until the Department receives documentation of corrections.

b. The Department shall issue a written notice of denial of license as prescribed in A.R.S. §§ 36-888 and 41-1076, if:

i. The applicant does not submit documentation of corrections within the time-frame in subsection (D)(1)(a); or

ii. Upon receipt of documentation of corrections from the applicant, the Department determines that the applicant or facility do not meet the requirements of A.R.S. § 36-881 *et seq.* and these rules.

2. If the applicant and facility meet the requirements of A.R.S. § 36-881 *et seq.* and these rules, the Department shall issue a license to the applicant.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Amended effective July 7, 1988 (Supp. 88-3). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-207. Changes Affecting License

A. A licensee shall notify the Department in writing at least 30 days before the date of a change in a facility's name. Within 30 days from the date of receipt of the notice, the Department shall issue an amended license that incorporates the change but retains the expiration date of the current license.

B. A licensee shall submit a written request to the Department at least 30 days before the date of an intended change in service classification, space utilization, or licensed capacity, that includes the type of change and a narrative description of the intended change.

1. Within 30 days from the date of receipt of the request, the Department shall review the requested change and send written notice of the review to the licensee. If the intended change:
   a. Complies with A.R.S. § 36-881 *et seq.* and these rules, the Department shall send the licensee an amended license that incorporates the change but retains the expiration date of the current license; or
   b. Does not comply with A.R.S. § 36-881 *et seq.* and these rules, the Department shall provide the licensee with written notice stating the requirements necessary for the Department to approve the requested change.
2. A licensee shall not implement any change until an amended license is issued.

C. A licensee shall notify the Department, in writing, 30 days before making a change in the ownership of a facility. A new owner shall obtain a license from the Department before beginning operation of the facility.

D. A licensee changing a facility's location shall apply for a new license as prescribed by R9-5-201. If the licensee has completed the training required in R9-5-201(A)(3), the licensee is not required to repeat the training.

E. A licensee that is a corporation or limited liability company shall notify the Department in writing within 30 days after the date of a change in any corporate or company officer or statutory agent.

F. A licensee that is a partnership or a joint venture shall notify the Department in writing within 30 days after the date of a change in members of the partnership or joint venture, or of an individual designated in writing by the licensee to accept service of process and subpoenas.

G. A licensee that is an association or cooperative, school governing board, or charter school shall notify the Department in writing within 30 days after the date of a change in the officers of the association, cooperative, school governing board, or charter school, or of the statutory agent or other individual designated in writing by the licensee to accept service of process and subpoenas.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-208. Inspections; Investigations

A. The Department shall inspect each facility before issuing an initial license or a renewal license, and as often as necessary to determine compliance with A.R.S. § 36-881 *et seq.* and these rules. Additionally, a licensee shall allow access to all areas of the facility affecting the health, safety, or welfare of a child or to which a child has access during hours of operation.

B. If the Department receives written or verbal information alleging a violation of A.R.S.§ 36-881 *et seq.* or these rules, the Department shall conduct an investigation to verify compliance. The licensee shall permit the Department to interview child care personnel and enrolled children for the investigation.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-209. Denial, Revocation, or Suspension of License

A. The Department may deny, revoke, or suspend a license to operate a facility if an applicant or licensee:

1. Provides false or misleading information to the Department;
2. Has been denied a certificate to operate a child care home or a license to operate a facility in any state, unless the denial was based on the applicant's failure to complete the licensing process in accordance with a required time-frame;
3. Has had a certificate or license to operate a child care home or facility revoked or suspended in any state;
4. Has had registration to operate or work in a child care facility in the state of Arizona revoked or denied; or
5. Fails to comply with any provision contained in A.R.S. § 36-881 *et seq.* or these rules.

B. In determining whether to deny, suspend, or revoke a license, the Department shall consider the threat to the health and safety of children in a facility based on such factors as:

1. Repeated violations of statutes or rules,
2. Pattern of non-compliance,
3. Type of violation,
4. Severity of violation, and
5. Number of violations.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-210. Repealed

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Amended subsection (A) effective July 7, 1988 (Supp. 88-3). Repealed effective October 17, 1997 (Supp. 97-4).

R9-5-211. Repealed

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6).
Repealed effective October 17, 1997 (Supp. 97-4).

ARTICLE 3. FACILITY ADMINISTRATION

R9-5-301. General Licensee Responsibilities

A. A licensee is responsible for the compliance of a facility with A.R.S. § 36-881 *et seq.* and these rules. The licensee shall designate a facility director who acts on behalf of the licensee and is responsible for the daily on-site operation of a facility. A licensee shall ensure that a facility director:
1. Designates in writing, an individual to act on behalf of the facility director when the facility director is not present in the facility and that the individual has access to all records necessary for performance of the facility director's duties.
   a. The individual shall be 21 years of age or older and provide documentation of:
      i. High school or high school equivalency diploma and 6 credit hours or more in early childhood, child development, or closely related field in an accredited college or university, or 30 actual hours of instruction, provided in conferences, seminars, lectures, or workshops in the areas of early childhood, child development, or closely related field, and 12 months or more of child care experience;
      ii. N.A.C., C.D.A., C.C.P., or C.P.C. credential and at least 12 months of child care experience;
      iii. A minimum of 24 credit hours from an accredited college or university, including at least 6 credit hours of course work in the areas of early childhood, child development, or closely related field, and 12 months of child care experience;
      iv. Associate degree from an accredited college or university in the areas of early childhood, child development, or closely related field, and 6 months of child care experience; or
      v. Bachelor degree from an accredited college or university in the areas of early childhood, child development, or closely related field, and 3 months of child care experience.
   b. A licensee has 12 months from the effective date of these rules to comply with this requirement.
2. Supervises or assigns a teacher-caregiver to supervise each staff member that does not meet the qualifications of R9-5-401(2) and each student-aide;
3. Prepares a dated attendance record for each day and ensures that each staff member records on the attendance record the time of each arrival and departure of the staff member.

B. A licensee shall develop and implement written facility policies and procedures required for the daily on-site operation of the facility as prescribed in A.R.S. § 36-881 *et seq.* and these rules.

C. A licensee shall ensure that parents are informed that they have access to all areas of a facility where child care services are provided during hours of operation and that parents are permitted to participate in any child care activity.

D. A licensee shall ensure that the following individuals are allowed immediate access to facility premises during hours of operation:
1. A parent or an individual designated in writing by the parent; or
2. A representative of:
   a. The Department,
   b. Local health department,
   c. Child Protective Services, or
   d. Local fire department or State Fire Marshal.

E. A licensee shall, with the exception of individuals listed in subsection (D), ensure that a staff member accompany and monitor any individual not registered with the Department, as prescribed by A.R.S. § 36-883.02, who is on facility premises to provide repair, maintenance, supplemental education, or other services where children are present.

F. A licensee shall ensure that each staff member and individual who is a resident at the facility submits 1 of the following documents provided by a health care provider as evidence of current freedom from pulmonary tuberculosis:
1. A report of a negative Mantoux skin test administered to a resident at the facility or to a staff member no later than 12 hours after the starting date of employment; or
2. A physician's written statement that the staff member or the individual who is a resident in the facility is currently free from tuberculosis.

G. If an enrolled child has an accident, injury, or emergency that requires medical treatment by a health care provider while attending a facility, the licensee shall ensure that a staff member:
1. Notifies the child's parent immediately after the accident, injury, or emergency;
2. Documents the date, time, and location of the child's accident, injury, or emergency, the method used to notify the parent, and the time the parent was notified; and
3. Maintains documentation of the accident, injury, or emergency on facility premises in a file that is separate from the current Emergency, Information, and Immunization card for 24 months from the date of the child's disenrollment.

H. A licensee shall ensure that at least 1 staff member who has current training in first aid and at least 1 staff member who has current training in CPR, as required by R9-5-403(E), is present at all times on facility premises, on field trips or while transporting enrolled children in a facility's motor vehicle or a vehicle designated by the licensee to transport children. This requirement may be met by a single staff member who has current training in both first aid and CPR.

I. A licensee shall prohibit the use or possession of the following items when an enrolled child is on facility premises, during hours of operation, or in any motor vehicle when used by the licensee for transportation of enrolled children:
1. Any beverage containing alcohol;
2. A controlled substance as listed in A.R.S. Title 36, Chapter 27, Article 2;
3. A dangerous drug as listed in A.R.S. § 13-3401(6);
4. A prescription medication as defined in A.R.S. § 32-1901(63) except where used in the manner prescribed; or
5. A firearm as defined by A.R.S. § 13-105(17).

J. At least once every 30 days and at different times of the day, a licensee shall ensure that an unannounced fire evacuation drill is conducted that includes each staff member and child at the facility.
1. If child care services for a child with special needs are provided at a facility, the licensee shall provide for the child's participation in each fire evacuation drill in accordance with the child's individualized plan as specified in R9-5-507(A)(1).
2. A licensee shall keep a written record of each fire evacuation drill on facility premises for 12 months from the date of the drill.

K. A licensee shall ensure that a written performance evaluation of each staff member is conducted every 12 months from the date of employment.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Amended effective July 7, 1988 (Supp. 88-3). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-302. Statement of Child Care Services

A. A licensee shall prepare a written statement regarding child care services that includes:
1. A description of the facility's child care services classifications in R9-5-205;
2. Hours of operation;
3. Child enrollment and disenrollment procedures;
4. Charges, fees, and payment requirements for child care services;
5. Child admission and release requirements;
6. Discipline guidelines and methods;
7. Transportation procedures;
8. Field trip requirements and procedures;
9. Responsibilities and participation of parents in facility activities;
10. A description of all activities and programs;
11. Liability insurance required by R9-5-308 that is carried by the licensee;
12. Medication administration procedures;
13. Emergency medical procedures;
14. A notice stating inspection reports are available, upon request; and
15. A provision stating that the facility is regulated by the Arizona Department of Health Services including the Department's address and telephone number.

B. A licensee shall provide a copy of the written statement of child care services:
1. To the Department:
   a. At the time the licensee's facility receives an initial license,
   b. Every 12 months from the date of the initial license as required by A.R.S. § 36-883.01, and
   c. When a change occurs in the child care services provided by the licensee; and
2. To a parent when:
   a. A parent's child is enrolled,
   b. A parent requests a copy of the written statement of child care services, or
   c. There is a change in the child care services provided by the licensee.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Amended Subsection (A) effective July 7, 1988 (Supp. 88-3). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-303. Posting of Notices

A. A licensee shall designate a wall area or notice board inside the facility's entrance, in a place that can be viewed by individuals entering or leaving the facility, for the posting of the:
1. Current license;
2. Name of facility director;
3. Name of the individual designated as prescribed by R9-5-301(A)(1) to act on behalf of the facility director when the facility director is not present in the facility;
4. Schedule of child care services fees and policy for the refund of fees as prescribed by A.R.S. § 36-882(K);
5. Breakfast, lunch, dinner, and snack menus for each calendar week at the beginning of the calendar week;
6. Notice of the presence of any communicable disease or infestation described in R9-6-202(C) from the date of discovery through the incubation period of the disease or infestation;
7. Notice of denial, revocation or suspension as prescribed by A.R.S. § 36-888;
8. Notice of an intermediate sanction imposed as prescribed by A.R.S. § 36-891.01;
9. Notice of legal injunction imposed as prescribed by A.R.S. § 36-886.01; and
10. Notice of the availability of facility inspection reports for public viewing.

B. A licensee shall ensure that the licensed capacity of each activity area or room is posted in that activity area or room.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-304. Enrollment of Children

A. A licensee shall require that a child be enrolled by the child's parent or an individual authorized in writing by the parent.

B. At the time of enrollment, a licensee shall require a child's parent to complete an Emergency, Information, and Immunization Record card that is signed by a parent containing:
1. The child's name, home address, home telephone number, sex, and date of birth;
2. The date of the child's enrollment;
3. The names, home and business addresses, and telephone numbers of the child's parents;
4. The names, addresses, and telephone numbers of individuals authorized by a parent to collect a child from the facility if the parent cannot be located;
5. The names of individuals not permitted by a parent to remove the child from a facility;
6. The names, addresses, and telephone numbers of a child's physician or health care provider and hospital;
7. The written authorization and parent instructions for emergency medical care of the parent's child when the parent cannot be contacted at the time of the emergency;
8. The written instructions of a parent or health care provider for nutritional and dietary needs of a child;
9. A written record completed by a parent or health care provider noting a child's susceptibility to illness, physical conditions of which child care personnel should be aware, and any individual requirements for health maintenance; and
10. A child's immunization record or a notation of exemption affidavit, required by R9-5-305(A).

C. A licensee shall maintain a current Emergency, Information, and Immunization Record card for each enrolled child on facility premises in a place that provides child care personnel ready access to the card in event of an emergency at, or evacuation of, the facility.

D. When a child is disenrolled from a facility, the licensee shall:
1. Enter the date of disenrollment on the child's Emergency, Information, and Immunization Record card; and
2. Maintain the records in subsection (D)(1) for 12 months from the date of disenrollment on facility premises in a place separate from the current Emergency, Information, and Immunization Record cards. If a licensee is a school governing board, a charter school, or a person operating multiple child care facilities, the licensee may maintain disenrollment records in a single central administrative

office located in the same city, town, or school attendance area as the facility.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Amended effective July 7, 1988 (Supp. 88-3). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-305. Child Immunization Requirements

A. A licensee shall not permit an enrolled child to attend a facility until the facility receives either a child's written immunization record or an exemption affidavit.
1. A child's immunization record provided by a parent shall contain the information required by A.A.C. R9-6-703 provided by a health care provider, stating that the child has received all current, age-appropriate immunizations required by the Department under A.A.C. R9-6-701(A) and (B).
2. An exemption affidavit provided by a parent shall consist of:
   a. A statement, signed by a child's health care provider, that the immunizations required by the Department as prescribed in A.A.C. R9-6-701(A) and (B) would endanger a child's health or medical condition; or
   b. A statement, signed by a child's parent, that the child is being raised in a religion whose teachings are in opposition to immunization.

B. A licensee shall ensure that a staff member updates a child's immunization record on the child's Emergency, Information, and Immunization Record card each time a parent provides the licensee with a written statement from a child's health care provider that the child has received an age-appropriate immunization required by R9-6-701(A) and (B).

C. If a child's immunization record indicates that a child has not received an age-appropriate immunization required by A.A.C. R9-6-701(A) and (B), a licensee shall ensure that a staff member:
1. Notifies a parent in writing that the child may attend the facility for not more than 15 days from the date of the notification unless the parent provides the facility with written evidence of the required immunization or an exemption affidavit as prescribed by subsection (A)(2); and
2. Documents in the child's immunization record the date on which a parent is notified of an immunization required by the Department.

D. If a licensee is notified by a parent, staff member, or health care provider, that a child or staff member has a communicable disease, the licensee shall ensure that child care personnel do not permit a child who lacks written evidence of immunity to the communicable disease to be present in the facility until:
1. A parent provides written evidence of the child's immunity to the disease; or
2. A local health department notifies the licensee that the child may return to the facility.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Amended effective July 7, 1988 (Supp. 88-3). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-306. Admission and Release of Children; Attendance Records

A. A licensee shall maintain a written or electronically logged and dated attendance form containing a child's name with the time of each admission and release of the child.
1. A licensee shall ensure that the attendance form is signed with at least a 1st initial and last name by each child's parent or individual designated in writing or by telephone by a parent, each time the child is admitted or released. An electronic fingerprint verification may be used in place of a signature of a parent or designated individual to verify identity before admitting or releasing a child.
2. Before releasing a child to an individual other than a parent, a licensee shall require each individual collecting a child to present picture identification.
3. A licensee shall not release a child to an individual other than a child's parent or other individual designated in writing by a parent except when the parent is unable to collect the child and authorizes the licensee by telephone to release the child to an individual not so designated. The licensee shall verify the telephone authorization using a means of verification that has been agreed upon between the licensee and the parent at the time of enrollment.
4. A licensee shall not permit the self-admission or self-release of an enrolled child unless the child is of school age and the licensee has obtained and verified written permission from the child's parent.
5. A licensee shall maintain the attendance form on facility premises for 12 months from the date of attendance.

B. A licensee shall ensure that a staff member prepares and maintains a roster each day for each child under the staff member's supervision that:
1. Is dated;
2. Lists the 1st and last name of each child physically present; and
3. Is maintained on facility premises for 3 months from the date of attendance.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Amended subsection (B) effective July 7, 1988 (Supp. 88-3). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-307. Suspected or Alleged Child Abuse or Neglect

A licensee or staff member shall document and report all suspected or alleged cases of child abuse or neglect.
1. A licensee or staff member shall report the suspected or alleged child abuse or neglect to Child Protective Services or to a local law enforcement agency as prescribed in A.R.S. § 13-3620. The licensee or staff member shall notify the Department of the suspected or alleged child abuse or neglect by any means available within 24 hours of the required report. The licensee or staff member shall also send written documentation to the Department, Child Protective Services, and any local law enforcement agency previously notified within 3 days of the initial report, and maintain written documentation of a child abuse or neglect report on facility premises for 12 months from the date of a report.
2. A licensee or staff member shall report the suspected or alleged child abuse by a staff member to the Department and to a local law enforcement agency as prescribed in A.R.S. § 13-3620. A licensee or staff member shall also send written documentation to the Department and to any law enforcement agency previously notified within 3

days of the initial report, and maintain written documentation of a child abuse report on facility premises for 12 months from the date of a report.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-308. Insurance Requirements

A. A licensee shall secure and maintain the following minimum insurance coverage:
1. General facility liability insurance of at least $300,000; and
2. Motor vehicle insurance coverage required by R9-5-517(A)(2) for each motor vehicle used by a licensee to transport enrolled children.

B. A licensee shall provide a copy of each certificate of insurance to the Department before issuance of a license and at any time that the licensee's insurance coverage expires, is canceled, or changes.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Amended effective July 7, 1988 (Supp. 88-3). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-309. Sanitation, Gas, and Fire Inspections

A. A licensee shall obtain the following health and safety inspections of a facility, according to the following schedules, and make any repairs or corrections stated on an inspection report before a license is issued by the Department:
1. Sanitation inspections, conducted a minimum of every 12 months by a local health department;
2. Gas inspections, conducted a minimum of every 12 months by a plumber holding a plumbing business license issued by a local government; and
3. Fire inspections, conducted a minimum of every 36 months by a local fire department or the State Fire Marshal.

B. A licensee shall maintain current reports of sanitation, gas, and fire inspections and documentation of any repairs or corrections on facility premises.

Historical Note
Adopted effective October 17, 1997 (Supp. 97-4).

ARTICLE 4. FACILITY STAFF

R9-5-401. Staff Qualifications

A licensee shall ensure that child care personnel meet the following qualifications for employment or volunteer service at a facility.
1. A facility director is 21 years of age or older and provides the licensee with written documentation of 1 of the following:
   a. High school or high school equivalency diploma and 6 credit hours or more in early childhood, child development, or closely related field in an accredited college or university, or 60 actual hours of instruction, provided in conferences, seminars, lectures, or workshops in the areas of early childhood, child development, or closely related field, and 24 months or more of child care experience;
   b. N.A.C., C.D.A., C.C.P., or C.P.C. credential and at least 18 months of child care experience;
   c. A minimum of 24 credit hours from an accredited college or university, including at least 6 credit hours of course work in the areas of early childhood, child development, or closely related field, and 18 months of child care experience;
   d. Associate degree from an accredited college or university in the areas of early childhood, child development, or closely related field, and 6 months of child care experience; or
   e. Bachelor degree from an accredited college or university in the areas of early childhood, child development, or closely related field, and 3 months of child care experience.
2. A teacher-caregiver is 18 years of age or older and provides the licensee with written documentation of 1 of the following:
   a. High school or high school equivalency diploma and 6 months of child care experience;
   b. N.A.C., C.D.A., C.C.P., or C.P.C. credential; or
   c. Associate or bachelor degree from an accredited college or university in the areas of early childhood, child development, or closely related field.
3. An assistant teacher-caregiver is 16 years of age or older and provides the licensee with written documentation of 1 of the following:
   a. Current and continuous enrollment in high school or a high school equivalency class,
   b. High school or high school equivalency diploma,
   c. Enrollment with a STRIVE program, or
   d. Enrollment in vocational rehabilitation as defined in A.R.S. § 23-501(8).
4. A student-aide provides the licensee with written documentation of enrollment in:
   a. A high school STRIVE program;
   b. An educational, curriculum-based course in child development, parenting, or guidance counseling; or
   c. A vocational education or occupational development program.
5. A volunteer is 16 years of age or older.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-402. Staff Records and Reports

A. A licensee shall maintain a file for each staff member containing:
1. The staff member's name, date of birth, home address, and telephone number;
2. Documents required by R9-5-401;
3. Name and telephone number of an individual or health care provider to be notified in case of emergency;
4. Documents required by R9-5-301(F);
5. The staff member's written statement attesting to current immunity against measles, rubella, diphtheria, and tetanus;
6. A copy of any current license or certification required by A.R.S. § 36-881 *et seq.* or these rules;
7. Written documentation from the Department verifying registration compliance with the Department according to A.R.S. § 36-883.02;
8. Written documentation of training provided by a licensee as required by R9-5-403;
9. The staff member's starting dates of employment or volunteer service;
10. The staff member's ending dates of employment or volunteer service, if applicable;

11. All written performance evaluations of the staff member conducted by the licensee as required by R9-5-301(K); and
12. At least 2 personal and 2 professional references, including at least 1 written personal reference and at least 1 written professional reference from a previous employer, and documentation of the licensee's good faith effort to contact each reference.

B. A licensee shall ensure that a staff member's information, required by subsections (A)(1) through (12), is maintained in a single location on facility premises. If a licensee is a school governing board, a charter school, or a person operating multiple child care facilities, the licensee shall maintain the information required by subsections (A)(1) through (10) on facility premises, but may maintain the information required by subsections (A)(11) and (12) in a single, central administrative office located in the same city, town, or school attendance area as the facility.

C. A licensee shall ensure the records and reports required by this rule are maintained throughout a staff member's period of employment or volunteer service and for 12 months from a staff member's last date of employment or volunteer service.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-403. Training Requirements

A. A licensee shall provide, and each staff member who provides child care services to children, shall complete within 10 days of the starting date of employment or volunteer service, training for new staff members that includes all of the following:
1. Facility philosophy and goals;
2. Names, ages, and needs of children to be assigned to a staff member;
3. Health needs, nutritional requirements, and information about adaptive devices of children for whom a staff member will provide child care services;
4. Lesson plans;
5. Child guidance and methods of discipline;
6. Hand washing techniques;
7. Diapering techniques and toileting, if assigned to diaper changing duties;
8. Food preparation, service, sanitation, and storage, if assigned to food preparation;
9. Infant formula preparation, if assigned to formula preparation;
10. Recognition of signs of illness and infestation;
11. Child abuse or neglect detection, prevention, and reporting;
12. Accident and emergency procedures;
13. Staff responsibilities as required by A.R.S. § 36-881 *et seq.* and these rules;
14. Sun safety policies and procedures; and
15. Safety on outdoor activity areas.

B. A licensee shall ensure that, every 12 months from a staff member's date of employment, the staff member completes 12 or more actual hours of training in 1 or more of the following areas:
1. Accident and emergency procedures, including CPR and first aid for infants and children;
2. Recognition of signs of illness and infestation;
3. Child growth and development;
4. Child abuse or neglect detection, reporting, and prevention;
5. Child guidance and methods of discipline;
6. Nutrition and developmentally appropriate eating habits;
7. Availability of community services and resources, including those available to children with special needs;
8. Parent involvement and communication with parents;
9. Program administration, planning, and development;
10. Environment of child care activity areas;
11. Sun safety policies and procedures; and
12. Safety on outdoor activity areas.

C. A licensee shall ensure that documentation of a staff member's completion of training required by subsection (A) is signed by the facility director and dated.

D. A licensee shall ensure that a staff member submits to the licensee documentation of training received as required by subsection (B) to the licensee as the training is completed.

E. A licensee shall ensure that a staff member required by R9-5-301(H) meets all of the following:
1. The staff member obtains first aid training specific to infants and children,
2. The staff member obtains CPR training specific to infants and children which includes a demonstration of the staff member's ability to perform CPR,
3. The staff member maintains current training in first aid and CPR, and
4. The staff member provides the licensee with a copy of the front and back of the current card issued by the agency or instructor as proof of completion of the requirements of this subsection.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Amended subsection (A) effective July 7, 1988 (Supp. 88-3). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-404. Staff-to-Children Ratios

A. A licensee shall ensure that at least the following staff-to-children ratios are maintained at all times when providing child care services to enrolled children:

Age Group	*Staff: Children*
Infants	1:5 or 2:11
1-year-old children	1:6 or 2:13
2-year-old children	1:8
3-year-old children	1:13
4-year-old children	1:15
5-year-old children not school-age	1:20
School-age children	1:20

B. A licensee shall ensure that child care personnel:
1. Place enrolled children in age-appropriate or developmentally appropriate groups;
2. Determine and maintain the required staff-to-children ratio for a group of children based on the age of the youngest child in the group;
3. Allow a volunteer to be counted as staff in staff-to-children ratios;
4. Not allow a student-aide to be counted as staff in staff-to-children ratios; and
5. When 6 or more children are present in a facility, not place an infant for supervision with children who are not infants.

C. A licensee shall ensure that at least 2 staff members are on facility premises when 6 or more children of any age group are present in a facility. At least 1 staff member shall be a teacher-caregiver. When 5 or fewer children are present, 1 teacher-caregiver shall be on facility premises and another staff member shall be available by telephone or other equally expeditious means and able to reach the facility within 15 minutes of notification.

D. A licensee may allow a staff member to perform duties other than child care if the duties are not undertaken simultaneously with the supervision of children in the staff member's charge.

E. In addition to maintaining the required staff-to-children ratios, a licensee shall ensure that staff members are present on facility premises to perform facility administration, food preparation, food service, and maintenance responsibilities. Facility maintenance shall not be dependent on the work of enrolled children.

F. When 6 or more enrolled children are participating in a field trip, a licensee shall ensure that a teacher-caregiver and at least 1 additional staff member are present on the field trip.

G. When transporting enrolled children who are not school age in a motor vehicle, a licensee shall maintain the staff-to-children ratios required by subsection (A) in addition to the motor vehicle driver unless 4 or fewer children are being transported.

H. When transporting children of school age in a motor vehicle, a licensee shall maintain the staff-to-children ratio required by subsection (A). A licensee may include the motor vehicle driver as staff in the staff-to-children ratio.

I. If a licensee conducts swimming activities at a swimming pool that has a lifeguard on the premises who has current lifesaving certification from the American Red Cross, a licensee shall maintain staff-to-children ratios required by subsection (A).

J. If a licensee conducts swimming activities at a swimming pool that does not have a lifeguard on the premises who has current lifesaving certification from the American Red Cross, the licensee shall maintain staff-to-children ratios stated in subsection (A) and have at least 1 additional staff member who:

1. Has a current lifesaving certificate from the American Red Cross; and
2. Is present in the pool or observing pool side while enrolled children are at the pool.

Historical Note

Adopted effective December 12, 1986 (Supp. 86-6). Amended effective July 7, 1988 (Supp. 88-3). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

ARTICLE 5. FACILITY PROGRAM AND EQUIPMENT

R9-5-501. General Child Care Program and Equipment Standards

A. A licensee shall ensure that:

1. The health, safety, or welfare of an enrolled child is not endangered;
2. All designated exits, corridors, and passageways that provide escape from the building are unobstructed and unlocked during hours of operation;
3. Combustible material such as paper, boxes, or rags is not permitted to accumulate inside or outside the facility premises;
4. Drinking water is provided sufficient for the needs of and accessible to each enrolled child in both indoor and outdoor activity areas;
5. Activity areas used by children are decorated with age-appropriate articles such as mirrors, bulletin boards, pictures, and posters;
6. Age-appropriate toys, materials, and equipment are provided to enable each child to participate in an activity.
   a. Toys, materials, and equipment are maintained in a clean condition.
   b. Storage space is provided in the facility for indoor and outdoor toys, materials, and equipment in areas accessible to enrolled children;
7. Clean clothing is available to a child when a child needs a change of clothing;
8. If a staff member places a child in a high chair when feeding a child:
   a. The high chair is equipped with a safety strap;
   b. The high chair is constructed to prevent toppling;
   c. The tray or feeding surface of the high chair is smooth and free of cracks; and
   d. The staff member:
      i. Fastens the safety strap while a child is in the high chair; and
      ii. Sanitizes the tray or feeding surface before each child's use;
9. The facility conforms to the standards prescribed in R9-5-511 and the following for a child who will be present at the facility during evening and nighttime hours:
   a. Permit a mat only when used on top of a cot;
   b. Before bathing a child at a facility, obtain written consent and bathing instructions from a parent and follow the instructions while bathing the child;
   c. Require that a staff member clean and sanitize a bathtub or shower stall after bathing each child;
   d. Require that a staff member remain awake while supervising a sleeping child; and
   e. Prohibit operation of a television set in a room where a child is sleeping.
10. The facility conforms to the standards prescribed in R9-5-511 and the following for naptime:
    a. A child is not permitted to lie in direct contact with the floor while napping;
    b. A television set is not operated in a room in which a child is napping;
    c. Naptime accommodations are available for an enrolled school-age child if requested by the child or a parent;
    d. Light is provided in naptime areas for observing a sleeping child; and
    e. An attic or loft is not used for naptime;
11. An activity area is equipped with at least 1 cot or mat, a sheet, and a blanket, where a child can be separated from other children for quiet time;
12. Written permission is obtained from a child's parent before allowing the child to participate in a swimming activity;
13. Outdoor activities are scheduled to allow not less than 75 square feet for each child occupying the facility's outdoor activity area at any time;
14. The facility's buildings, premises, and indoor and outdoor play equipment are maintained in good repair and free from hazards;
15. The facility conforms to the following heating and cooling standards:
    a. Temperatures are maintained between 68° F and 82° F in each room used by children;
    b. Heating and cooling equipment is inaccessible to children;
    c. Fans are mounted and inaccessible to children;
    d. An unvented or open-flame space heater or portable heater is not used on the facility premises; and
    e. A gas valve on an unused gas outlet is removed and capped where it emerges from the wall or floor;
16. The facility conforms to the following lighting and electrical standards:
    a. Except when a child is napping or sleeping, each room used by enrolled children is maintained at a minimum of 30 foot candles of illumination;
    b. Each unused electrical outlet is covered with a safety plug cover or insert;

c. Crockpots and hot plates are used only in a kitchen and are inaccessible to children; and
d. Electrical extension cords are not used;

17. The facility conforms to the following toilet room standards:
    a. Plumbing fixtures are maintained in a clean and working condition;
    b. Chipped or cracked sinks and toilets are replaced or repaired;
    c. Toilet rooms are ventilated to the outside of the building, either by a screened window open to the outside air or by an exhaust fan and duct system that is operated when the toilet room is in use;
    d. A toilet room with a door that opens to the exterior of a building is equipped with a self-closing device that keeps the door closed except when an individual is entering or exiting; and
    e. A toilet room door does not exit into a kitchen;
18. Storage space is provided in the facility for cots, mats, sheets, and blankets accessible to an area used for naptime or sleeping and separate from food service and preparation, toilet rooms, and laundry rooms;
19. Each child's toothbrush, comb, washcloth, cloth towel, and clothing is maintained in a clean condition and stored in an identified space separate from those of other children;
20. All materials and chemicals labeled as a toxic or flammable substance are stored in an area inaccessible to children that is locked with a key or combination lock and is separate from food storage areas;
21. All substances that may be a hazard to a child and have a child warning label are inaccessible to children and stored separately from food storage areas; and
22. Garden tools, lawn mowers, ladders, and other facility equipment presenting a hazard to children are stored in an area inaccessible to children.

B. A licensee shall ensure that a staff member:
1. Supervises enrolled children at all times;
2. Reports any suspected or alleged child abuse or neglect according to procedures prescribed in R9-5-307;
3. Does not smoke or use tobacco on facility premises except in designated areas separated from the children;
4. Cleans each enrolled child before and after each meal and changes a child's clothing when wet or soiled;
5. Prepares, and posts in each activity area, a current schedule of children's age-appropriate activities, including the times the following are provided:
    a. Meals and snacks;
    b. Naps;
    c. Indoor and outdoor activities;
    d. Quiet and active activities;
    e. Teacher-directed activities;
    f. Self-directed activities;
    g. Activities for individuals, groups of 5 or fewer children, and groups of 6 or more children; and
    h. Activities that develop small and large muscles;
6. Prepares and posts a dated lesson plan in each activity area for each calendar week which is maintained on facility premises for 12 months from the lesson plan date and provides opportunities for each child to:
    a. Gain a positive self-concept;
    b. Develop and practice social skills;
    c. Think, reason, question, and experiment;
    d. Acquire language skills;
    e. Develop physical coordination skills;
    f. Develop habits that meet health, safety, and nutritional needs;
    g. Express creativity;
    h. Learn to respect cultural diversity of children and staff;
    i. Learn self-help skills; and
    j. Develop a sense of responsibility and independence;
7. Does the following when a parent permits or asks a staff member to use external personal products for a child, such as petroleum jelly, diaper rash ointments, sun screen or sun block preparations, and baby diapering preparations:
    a. Obtains the child's personal products from the parent or, if the licensee provides the personal products for use by the child, obtains written approval for use of the products from the parent;
    b. Labels the personal products with the child's 1st and last name; and
    c. Keeps the personal products inaccessible to children;
8. Places a child's wet or soiled laundry in a plastic bag labeled with the child's name, stores the laundry in a container covered with a tight fitting lid, and sends the laundry home when the facility releases the child to the child's parent; and
9. Monitors a child for overheating or overexposure to the sun. If a child exhibits signs of overheating or overexposure to the sun, a staff member who has the first aid training required by R9-5-403(E) shall evaluate and treat the child.

Historical Note

Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-502. Supplemental Standards for Infants

A. In addition to complying with all child care standards, a licensee providing child care services for infants shall:
1. Separate infants from children older than 12 months of age. Within 24 months from the effective date of these rules, a facility shall provide a wall enclosed room that provides exits required by R9-5-602(A) to separate infants from children older than 12 months of age;
2. Post a list in each infant room stating each infant's name and assigned staff member;
3. Provide active and quiet activities;
4. Provide indoor and outdoor activities;
5. Permit an infant to maintain an established pattern of sleeping and waking;
6. Provide an outdoor activity area that is scheduled for use by infants when children older than infants are not present;
7. Provide space, materials, and equipment in an infant room that includes the following:
    a. An area with nonabrasive carpeting for sitting, crawling, and playing;
    b. Toys, materials, and equipment in a quantity sufficient to meet the needs of the infants in attendance that include:
        i. Toys for stacking, pulling, and grasping;
        ii. Soft toys;
        iii. Books;
        iv. Mobiles;
        v. Unbreakable mirrors; and
        vi. Outdoor play equipment; and

c. At least 1 adult-size chair for staff members' use when holding or feeding an infant;

8. Provide a crib for each infant that:
   a. Has bars or openings spaced no more than 2-3/8 inches apart and a crib mattress measured to fit not more than ½ inch from the crib side;
   b. Has a commercially waterproofed mattress; and
   c. Is furnished with clean, sanitized, crib-size bedding, including a fitted sheet and top sheet or a blanket.
9. Prohibit the use of stacked cribs; and
10. Arrange the cribs to maintain a minimum spacing between cribs that is not less than 2 feet on any crib side that has bars or other openings, except when:
    a. A crib side with bars is next to a wall; or
    b. A crib end does not have bars and the cribs are placed end to end.

B. A licensee providing child care services for infants shall not:
1. Allow an infant room to be used as a passageway to another area of the facility;
2. Permit an infant who is awake to remain for more than 30 consecutive minutes in a crib, playpen, swing, high chair, infant seat, or other equipment that confines movement; or
3. Permit a child to use a walker, except a child with special needs for whom a walker is prescribed by a health care provider.

C. A licensee shall ensure that:
1. A staff member assigned to infants in an infant room:
   a. Plays and talks with each infant;
   b. Holds and rocks each infant;
   c. Responds immediately to each infant's distress signals;
   d. Keeps a dated, daily, written record of each infant's activities, food consumption, and diaper changes, and maintains the record on facility premises for 3 months from the record date. A staff member shall provide a copy of this record to the infant's parent upon request;
   e. Removes soft pillows and toys from a crib when an infant is sleeping;
   f. Cleans and sanitizes each crib and mattress used by an infant when soiled;
   g. Changes each crib sheet and blanket before use by another child, when soiled, or at least every 24 hours; and
   h. Cleans and sanitizes all sheets and blankets before use by another child.
2. A staff member assigned to an infant in an infant room does not:
   a. Place an infant directly on a waterproof mattress cover;
   b. Restrain an infant in a crib or other restrictive equipment; or
   c. Place an infant in a crib or other equipment that confines movement for disciplinary reasons.
3. Before feeding an infant, a staff member:
   a. Obtains dated, written instructions from a parent or health care provider regarding the method of feeding and types of foods to be prepared or fed to an infant at the facility;
   b. Updates the written instructions as foods or methods are added or changed;
   c. Posts the current written instructions in the kitchen and infant room and maintains the instructions on facility premises for 3 months from the date of the instructions; and
   d. Follows the current written instructions of a parent when feeding the infant.
4. When preparing, using, or caring for an infant's feeding bottles, a staff member:
   a. Labels each bottle received from the parent with the child's 1st and last name;
   b. Ensures that a bottle is not:
      i. Heated in a microwave oven,
      ii. Propped for an infant feeding, or
      iii. Permitted in an infant's crib unless the written instructions required by subsection (C)(3) state otherwise;
   c. Empties and rinses bottles previously used by an infant; and
   d. Cleans and sanitizes using heat only, a bottle, bottle cover, and nipple before reuse.
5. When feeding an infant, a staff member:
   a. Provides an infant with food for growth and development that includes:
      i. Formula provided by a parent or the licensee that is prepared and stored in a sanitary manner at the facility, following written instructions required by subsection (C)(3);
      ii. Cereal as requested by a parent or health care provider. A staff member shall not mix cereal with formula and feed it to an infant from a bottle or infant feeder unless the written instructions required by subsection (C)(3) state otherwise; and
      iii. Solid foods as requested by a parent. A staff member shall feed solid food to an infant by spoon from an individual container. A separate container and spoon shall be used for each infant;
   b. Holds and feeds an infant under 6 months of age and an infant older than 6 months of age who cannot hold a bottle for feeding; and
   c. If an infant is no longer being held for feeding, seats the infant in a high chair or at a table with a chair that allows the child to reach the food while sitting.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-503. Standards for Diaper Changing

A. A licensee shall provide a diaper changing area in each activity area as required in R9-5-602(C) that consists of:
1. A nonabsorbent, sanitizable diaper changing surface that is:
   a. Seamless and smooth; and
   b. Kept clear of items not required for diaper changing;
2. A hand washing sink next to the diaper changing surface for staff use when changing diapers and for washing a child during or after diapering, that provides:
   a. Running water between 86° F and 110° F,
   b. Antibacterial soap from a dispenser, and
   c. Single-use paper hand towels from a dispenser; and
3. At least 2 waterproof, sanitizable containers with waterproof liners and tight fitting lids. Separate containers shall be used for soiled diapers and soiled clothing. A licensee shall ensure that:
   a. The containers are inaccessible to children;
   b. A staff member:
      i. Empties clothing soiled with feces into a flush toilet without rinsing;

ii. Places clothing soiled by feces or urine in a plastic bag labeled with a child's name, stores the clothing in a container used for this purpose, and sends the clothing home with the child's parent; and
iii. Removes disposable diapers and disposable training pants from a diaper changing area as needed or at least twice every 24 hours to a waste receptacle outside the facility building.

B. A licensee shall ensure that a staff member does not:
1. Permit a bottle, formula, food, eating utensil, or food preparation in a diaper changing area;
2. Draw water for human consumption from a diaper changing area sink; or
3. If responsible for food preparation, change diapers until food preparation duties have been completed for the day.

C. A licensee shall ensure that a written diaper changing procedure is posted and implemented in each diaper changing area. The procedure shall state that a child's diaper shall be changed as soon as it is soiled, and that a staff member, when diapering, shall:
1. Use a separate wash cloth and towel only once for each child;
2. Wash and dry a child using the child's individual personal products labeled with the child's 1st and last name;
3. Use single-use disposable latex gloves;
4. Wash his or her own hands with antibacterial soap and running water between 86° F and 110° F before and after each diaper change;
5. Wash each child's hands with antibacterial soap and running water between 86° F and 110° F after each diaper change;
6. Clean, sanitize, and dry the diaper changing surface following each diaper change; and
7. Use single-use paper towels from a dispenser to dry the diaper changing surface or the hands of a child or staff member.

D. A licensee shall ensure that a staff member:
1. Keeps a dated log for each day in each diaper changing area, listing each time the child's diaper has been changed; and
2. Maintains the diaper changing log on facility premises for 3 months from the date of the log.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-504. Supplemental Standards for 1-year-old and 2-year-old Children
In addition to complying with all child care standards, a licensee providing child care services for 1-year-old and 2-year-old children shall:
1. Ensure that a staff member does not permit a 1-year-old or 2-year-old child who is awake to spend more than 30 minutes of consecutive time in a crib, high chair, playpen, or other place of confinement;
2. Consult with each child's parent to develop a mutual plan for individual toilet training of the child and ensure that a staff member does not force toilet training on any child;
3. Ensure that each activity area has a supply of age-appropriate toys, materials, and equipment in a quantity sufficient to meet the needs of the children in attendance.
   a. Toys, materials, and equipment include:
      i. Books, including cloth books;
      ii. Rubber or soft plastic balls;
      iii. Puzzles and toys to enhance manipulative skills;
      iv. Blocks;
      v. Washable soft toys, stuffed animals, and dolls;
      vi. Musical instruments; and
      vii. Indoor and outdoor equipment to enhance large muscle development;
   b. Toys, materials, and equipment are:
      i. Too large for a child to swallow; and
      ii. Free of sharp edges and points;
4. Ensure that:
   a. If finger food is served, the food is of a size and texture that does not present a choking hazard;
   b A staff member serves food to a child in a high chair or at a table with a chair that allows the child to reach the food while sitting; and
   c. If a child is fed with a bottle, a staff member complies with the requirements set forth in R9-5-502(C)(4).

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-505. Supplemental Standards for 3-year-old, 4-year-old and 5-year-old Children
In addition to complying with all child care standards, a licensee providing child care services for 3-year-old, 4-year-old, and 5-year-old children shall provide a supply of age-appropriate toys, materials, and equipment in each activity area in a quantity sufficient to meet the needs of the children in attendance. Toys, materials, and equipment shall include:
1. Art supplies,
2. Blocks,
3. Books and posters,
4. Toys and dress-up clothes,
5. Indoor and outdoor equipment to enhance large muscle development,
6. Puzzles and toys to enhance manipulative and categorization skills,
7. Science materials, and
8. Musical instruments.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Amended subsection (F) effective July 7, 1988 (Supp. 88-3). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-506. Supplemental Standards for School-age Children

A. In addition to complying with all child care standards, a licensee providing child care services for school-age children shall:
1. Unless a child has permission from a parent for self-release from a facility as prescribed in R9-5-306(A)(4), require that a staff member accompany and supervise a child in a school-age program while en route to and from:
   a. The school attended by the child; or
   b. The bus stop used by the child. A staff member shall remain with the child at the bus stop until the child boards the bus; and
2. Require a staff member to supervise a school-age child while en route to and from a bathroom and allow the child privacy while in the bathroom. If a child remains in the bathroom for more than 3 minutes, the supervising staff member shall check on the child to ensure the child's safety.

B. A licensee shall separate an indoor activity area for school-age children from an indoor activity area provided for infants or 1-year-old children.

C. A licensee shall provide age-appropriate toys, materials, and equipment including:
1. Arts and crafts,
2. Games,
3. Puzzles and toys to enhance manipulative skills,
4. Books,
5. Science materials,
6. Sports equipment, and
7. Outdoor play equipment.

D. A licensee shall provide school-age children with a quiet study area.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-507. Supplemental Standards for Children with Special Needs

A. In addition to complying with all child care standards, a licensee providing child care services for a child with special needs shall:
1. Upon enrollment of a child with special needs, obtain from the child's parent a copy of an existing individualized plan for the child that can be reviewed, adopted, and followed by the licensee when providing child care services to the child. An individualized plan shall include the following as needed for the child:
   a. Medication schedule;
   b. Nutrition and feeding instructions;
   c. Qualifications required of a staff member who feeds the child;
   d. Medical equipment or adaptive devices;
   e. Medical emergency instructions;
   f. Toileting and personal hygiene instructions;
   g. Specific child care services to be provided to the child at the facility;
   h. Information from health care providers, including the frequency and length of any prescribed medical treatment or therapy;
   i. Training required of a staff member to care for the child's special needs; and
   j. Participation in fire evacuation drills.
2. If a child with special needs does not have an existing individualized plan, obtain from the child's parent written instructions for providing services to the child until a written individualized plan containing the information in subsection (A)(1) is developed by a team consisting of staff members, the child's parent, and health care providers. An individualized plan shall be completed within 30 days of the child's enrollment;
3. Maintain a child's current individualized plan on facility premises and provide a copy to the child's parent; and
4. Ensure the individualized plan is updated at least every 12 months from the date of the initial plan or as changes occur.

B. If a child with special needs who is 18 months of age or older and does not walk is placed in an infant group, a licensee may move the child to a 1-year-old group after a parent and the licensee determine that the proposed move is developmentally appropriate.

C. A licensee shall ensure that a staff member does not prepare formula for tube-feeding a child. All formula for tube-feeding shall be commercially prepackaged in a ready-to-use state or brought by a parent to the facility in an unbreakable container. The feeding and clearing of a child's feeding apparatus shall be performed by a staff member instructed by a parent or individual designated by a parent.

D. A licensee shall provide a child with special needs with:
1. Developmentally appropriate toys, materials, and equipment; and
2. Assistance from staff members to enable the child to participate in the activities of the facility.

E. In addition to complying with the transportation requirements in R9-5-517, a licensee transporting a child with special needs in a wheelchair in a facility's motor vehicle shall ensure that:
1. The child's wheelchair is secured in the motor vehicle using a minimum of 4 anchorages attached to the motor vehicle floor, and 4 securement devices, such as straps or webbing that have buckles and fasteners, that attach the wheelchair to the anchorages;
2. The child is secured in the wheelchair by means of a wheelchair restraint that is a combination of pelvic and upper body belts intended to secure a passenger in a wheelchair; and
3. The child's wheelchair is placed in a position in the motor vehicle that does not prevent access to the child in the wheelchair or passage to the front and rear in the motor vehicle.

F. A licensee providing child care services for a child who uses a wheelchair or is not able to walk shall locate the child on the ground floor of the facility.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-508. General Nutrition Standards

A. A licensee shall make the following meals available:
1. Breakfast to an enrolled child who is present at a facility before 8 a.m.,
2. Lunch to an enrolled child who is present at a facility between 11 a.m. and 1 p.m., and
3. Dinner to an enrolled child who is present between 5 p.m. and 7 p.m. and who will remain at the facility after 7 p.m.

B. A licensee shall serve the following meals or snacks to an enrolled child present at a facility for the following periods of time:
1. If an enrolled child is present 2 to 4 hours, 1 or more snacks. If an enrolled child is present during any of the meal times stated in subsection (A), a meal that meets the meal pattern requirements in subsection (C);
2. If an enrolled child is present 4 to 8 hours, 1 or more snacks and a meal;
3. If an enrolled child is present 9 or more hours, 2 snacks and 1 or more meals; and
4. Before bedtime, 1 snack.

C. If a licensee provides food, a licensee shall prepare and serve food according to the meal pattern requirements found in Table 1, "Table of Meal Pattern Requirements for Children".

D. If a parent provides food for the parent's child, the licensee shall provide milk or juice to the child if not provided by the parent.

E. If a licensee plans and serves meals, the meals shall:
1. Meet the age-appropriate nutritional requirements of a child; and
2. For each calendar week, provide a variety of foods within each food group from the meal pattern requirements.

F. A licensee shall maintain at least 1 day's supply of food needed to serve meals and snacks as required by subsection (C) to each child attending the facility;

G. In addition to the required daily servings of food stated in subsection (C), a licensee shall make 2nd servings of food available to each child at meals and at snack time.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-509. General Food Service and Food Handling Standards

A. A licensee that prepares or serves food to enrolled children on the facility premises shall comply with A.A.C. R9-8-111 through R9-8-135, local ordinances, and requirements of the local health department where the facility is located. If a licensee contracts with a food service establishment defined in A.A.C. R9-8-112(13), to prepare and deliver food to the facility, the licensee shall obtain and provide the Department with a copy of the food service establishment's permit, issued as prescribed by A.A.C. R9-8-119, at the following times:
1. Before the Department issues a license to the facility,
2. Upon contracting with the food service establishment, and
3. Every 12 months from the date the food service contract is entered into while the contract is in effect.

B. A licensee that stores, displays, transports, prepares, or serves food shall:
1. Protect food from contamination;
2. Prohibit storage of food in a bathroom;
3. Store perishable foods requiring cold storage in a refrigeration unit at temperatures that do not exceed 45° F or freezer at temperatures that do not exceed 0° F. Each refrigeration unit or freezer shall be fitted with a thermometer to measure the inside air temperature;
4. Maintain perishable foods requiring hot storage at a temperature of at least 140° F, except during food preparation; and
5. Provide a metal stem-type thermometer to measure the temperatures of foods.

C. A licensee shall ensure that a utensil, container, surface, or appliance used for eating, drinking, or food preparation is clean. All single-service articles as defined in A.A.C. R9-8-112(30) shall be disposed of after each use.

D. A licensee shall ensure that staff members wash their hands with antibacterial soap and running water before preparing or serving food or washing utensils.

E. When a licensee serves milk, vegetable juice, or fruit juice, the licensee shall ensure that the staff member:
1. Serves fresh milk from a commercially filled container and does not return an unused portion to a commercial container. This rule supersedes A.A.C. R9-8-132(E)(2);
2. Does not substitute fresh milk with dry milk that has been reconstituted;
3. Does not replace fresh milk with any other food in the meal pattern requirement; and
4. Serves 100% full-strength fruit or vegetable juices.

F. A licensee shall require that each child:
1. Washes hands with antibacterial soap and running water before handling or eating food.
   a. A staff member may use a washcloth to wash the hands of an infant or a child with special needs if indicated in the child's individualized plan; and
   b. To reduce the transfer of bacteria, a washcloth shall be used only once for an infant or a child with special needs;
2. Is not served or permitted to eat directly off the floor or ground or with utensils placed directly on the floor or ground;
3. Is encouraged but not forced by a staff member to eat foods served at a facility;
4. Is assisted in eating when necessary; and
5. Is taught self-feeding skills and habits of good nutrition.

G. Before the facility's 1st food service of the calendar week, a licensee shall ensure a dated menu specifying foods to be served on each day the facility is operating during the calendar week is posted in the facility.
1. If a licensee serves a substitution for a food specified on the posted menu, the substitution shall be noted on the posted menu before the facility's 1st food service of the day.
2. A licensee shall maintain a menu on facility premises for 3 months from the date of the menu.

H. When a parent provides specific dietary instructions for a child, a licensee shall post the instructions in the kitchen and the child's activity area and serve the child foods as instructed.

I. A licensee shall not permit children in a kitchen during food preparation and food service except as part of an activity.

J. A licensee shall not allow a food preparation or food storage area to be used as a passageway by children.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-510. Discipline and Guidance

A. A licensee shall ensure that a staff member:
1. Defines and maintains consistent, reasonable rules, and limitations for a child's behavior and teaches, models, and encourages orderly conduct, personal control, and age-appropriate behavior;
2. Explains to a child why a particular behavior is not allowed, suggests an alternative, and assists the child to become engaged in an alternative activity; and
3. After determining that a child's behavior may result in harm to self or others, holds the child until the child regains control or composure.

B. A licensee shall ensure that a staff member does not use or permit:
1. A method of discipline that could cause harm to the health, safety, or welfare of a child;
2. Corporal punishment;
3. Discipline associated with:
   a. Eating, napping, sleeping, or toileting;
   b. Medication; or
   c. Mechanical restraint; or
4. Discipline administered to any child by another child.

C. A licensee may allow a staff member to separate a child from other children for unacceptable age-appropriate behavior.
1. The separation period shall be for no longer than 3 minutes after the child has regained control or composure.
2. A staff member shall not allow a child to be separated for longer than 10 minutes without the staff member interacting with the child.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-511. Sleeping Materials and Equipment

A. A licensee shall provide each child who naps or sleeps at the facility with a separate cot, mat, or a crib that meets the requirements of R9-5-502(A)(8) and ensure that:
1. A cot, mat, or crib used by a child accommodates the child's height and weight;
2. A staff member covers each cot, crib mattress, or mat with a clean sheet that is laundered when soiled, or at least once every 7 days and before use by a different child;
3. A clean blanket or sheet is available for each child;
4. A rug, carpet, blanket, or towel is not used as a mat; and
5. Each cot, mat, or crib is maintained in a clean and repaired condition.

B. A licensee shall not use bunk beds or waterbed mattresses.

C. A licensee shall provide an unobstructed passageway at least 18 inches wide between each row of cots, or mats to allow a staff member access to each child.

D. A licensee shall ensure that cribs, cots, and mats do not obstruct access to designated exits.

Historical Note

Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-512. Cleaning and Sanitation

A. A licensee shall maintain facility premises free of insects and vermin.

B. A licensee shall maintain facility premises and furnishings in a clean condition and free from odor.
1. Floor coverings, such as carpeting, tile, linoleum, or wood shall be clean, washable, and free from cracks, chips, gaps, rips, dampness, or odors.
2. A licensee shall ensure that toilet bowls, lavatory fixtures, and floors in toilet rooms and kitchens are cleaned and sanitized as often as necessary to maintain them in a clean and sanitized condition or at least once every 24 hours.

C. If laundry belonging to a facility is done on facility premises, a licensee shall:
1. Not use a kitchen or food storage area for sorting, handling, washing, or drying laundry;
2. Locate the laundry equipment in an area that is separate from licensed activity areas and inaccessible to enrolled children;
3. Not permit a child to be in a laundry room or use a laundry area as a passageway for enrolled children; and
4. Ensure that laundry soiled by vomitus, urine, feces, blood, or other body fluid is stored, cleaned, and sanitized separately from other laundry.

D. A licensee shall ensure that:
1. Each toilet room in a facility contains, within easy reach of children:
   a. Mounted toilet tissue;
   b. A sink with running water;
   c. Antibacterial soap contained in a dispenser; and
   d. Disposable, single-use paper towels in a mounted dispenser, or a mechanical air hand dryer;
2. Staff members wash their hands with antibacterial soap and running water after toileting;
3. A child's hands are washed with antibacterial soap and running water after toileting;
4. Food waste is stored in a container with a tight fitting lid.
   a. The container is clean and lined with a plastic bag.
   b. Food waste and other refuse is removed from the facility building at least once every 24 hours or more often as necessary to maintain a clean condition and avoid odors; and
5. A staff member does not draw water for human consumption from a toilet room hand washing sink.

Historical Note

Adopted effective December 12, 1986 (Supp. 86-6). Amended subsection (P) effective July 7, 1988 (Supp. 88-3). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-513. Pets and Animals

A. A licensee shall maintain written documentation of current immunization against rabies for each dog or cat owned by a licensee or staff member that is present on facility premises.

B. A licensee shall ensure that child care personnel:
1. Keep all pet and animal habitats clean;
2. Prohibit reptiles such as turtles, iguanas, snakes, and lizards in the facility;
3. Prohibit birds in food preparation and eating areas;
4. Control pets and animals to maintain the cleanliness of the facility and prevent the pets and animals from endangering a child, staff member, or other individual on the premises; and
5. Keep birds and animals such as horses, sheep, cattle, and poultry in an enclosure that is not accessible to enrolled children except as part of an activity.

Historical Note

Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-514. Accident and Emergency Procedures

A. A licensee shall maintain a first aid kit accessible to staff members but inaccessible to children. The kit shall contain first aid supplies in a quantity sufficient to meet the needs of the enrolled children and include the following:
1. Adhesive band-aids of assorted sizes,
2. Antiseptic solution or sealed antiseptic wipes,
3. Sterile bandages,
4. Sterile gauze pads,
5. A pair of scissors,
6. Adhesive tape,
7. Disposable latex gloves, and
8. Reclosable plastic bags of at least 1-gallon size.

B. A licensee shall prepare a written accident, evacuation, and emergency plan and maintain the plan on facility premises in a location accessible to staff members and update the plan every 12 months from the date of initial preparation or when any information changes. The plan shall contain:
1. The location of the first aid kit;
2. The names of staff members who have the first aid training required by R9-5-403(E);
3. The names of staff members who have the CPR training required by R9-5-403(E);
4. The directions for verbal notification of a parent by telephone or other equally expeditious means within 30 minutes of an accident or emergency, and directions for written notification to the parent within 24 hours; and
5. The facility's street address and the emergency telephone numbers for the local fire department, police department, ambulance service, and poison control center.

C. A licensee shall post, near an activity area or a room's designated exit, a building evacuation plan that details the designated exits from the activity area or room and the facility.

D. A licensee shall maintain a communication system that consists of:

1. A direct-access, in-and-out, operating telephone service on the facility; or
2. A 2-way voice communication system that connects the facility with an individual who has direct access to an in-and-out, operating telephone service.

E. A licensee shall post the accident, evacuation, and emergency plan required in subsection (B) in any facility activity area that does not have an operable telephone service or 2-way voice communication system.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-515. Illness and Infestation

A. A licensee shall not permit a child to remain at the facility if a staff member determines that a child shows signs of illness or infestation.

B. If a child exhibits signs of illness or infestation at a facility, a licensee shall ensure that a staff member:
1. Immediately separates the child from other children,
2. Immediately notifies the child's parent by telephone or other expeditious means to arrange for the child's removal from the facility, and
3. Keeps a written record of notification on facility premises for 3 months from the date of notification.

C. A licensee shall ensure that a staff member who has signs of illness or infestation is excluded from a facility. A facility director shall not permit a staff member to return to a facility until free from signs of illness or infestation, or until the staff member provides written documentation by a health care provider that the individual may return to a facility.

D. If a staff member or enrolled child contracts a communicable disease or infestation as stated in A.A.C. R9-6-202(C), a licensee shall ensure that, within 24 hours of notice of the communicable disease or infestation, written notice is provided to each staff member, parent, and the local health department. A licensee shall ensure that:
1. A dated, written notice of the communicable disease or infestation is prepared and posted in the facility's entrance as required by R9-5-303;
2. A written record of the notification is maintained on facility premises for 12 months from the date of notification; and
3. A written record of the absences of staff members and children due to a communicable disease or infestation stated in A.A.C. R9-6-202(C) is prepared and maintained on facility premises for 12 months from the 1st date of absence.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-516. Medications

A. A licensee shall ensure that a written statement is prepared and maintained on facility premises that specifies whether prescription or nonprescription medications are administered to enrolled children. If prescription or nonprescription medications are administered, the written statement shall contain provisions explaining that:
1. A facility director, or a staff member designated in writing by the facility director, is responsible for the administration of all medications in the facility, including storing, supervising a child's ingestion of a medication, and recording all medications administered to a child. A facility director shall ensure that only 1 staff member in the facility at any given time is responsible for the administration of medications;
2. A facility director, or a staff member designated in writing by the facility director, shall not permit the administration of a medication to a child unless the facility receives written authorization signed by the child's parent or health care provider that includes the:
   a. First and last name of the child;
   b. Name of the medication;
   c. Prescription number, if any;
   d. Instructions for administration specifying the:
      i. Dosage and route of administration;
      ii. If indicated, starting and ending dates of the dosage period; and
      iii. Times and frequency of administration;
   e. Reason for the medication; and
   f. Date of authorization; and
3. A staff member shall:
   a. Administer a prescription medication provided by a parent only from a container dispensed by a pharmacy;
   b. Administer a nonprescription medication provided by a parent for a child only from a container prepackaged and labeled for use by the manufacturer and labeled with the child's name; and
   c. Not administer any medication that has been transferred from one container to another.

B. A licensee shall allow a child to receive an injection only after obtaining a written authorization from a physician. Only those health care providers authorized by state law to give injections are permitted to give injections to an enrolled child. A licensee shall maintain the physician's written injection authorization on facility premises for 12 months from the date of the authorization.

C. A licensee shall maintain a written record of all medications administered to an enrolled child.
1. The record shall contain:
   a. The 1st and last name of the child;
   b. The name and amount of medication administered and the prescription number, if any;
   c. The date and time the medication was administered; and
   d. The signature of the staff member who administered the medication to the child.
2. A licensee shall maintain the record on facility premises for 12 months from the date the medication is administered.

D. A licensee shall return all unused prescription and nonprescription medications to a parent when the medication prescription date has expired or the medication is no longer being administered to the child or dispose of the medication if unable to locate the child's parent after the child's disenrollment.

E. A licensee shall ensure that prescription and nonprescription medications are stored as follows:
1. A child's medication is kept in a locked, leakproof storage cabinet or container that is used only for storing children's medications and is located out of reach of children;
2. Medication for a staff member is kept in a locked, leakproof storage cabinet or container that is separate from the storage container for children's medications and is located out of reach of children; and
3. Medications requiring refrigeration are kept in a locked, leakproof container in a refrigerator.

F. A licensee shall ensure that a facility does not stock a supply of medications for administration to enrolled children, including:
1. Any prescription medication; or
2. A nonprescription medication such as aspirin, acetaminophen, ibuprofen, or cough syrup.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-517. Transportation

A. A licensee providing transportation to enrolled children in a motor vehicle that the licensee owns or acquires for use by contract shall:
1. Ensure that the motor vehicle is registered by the Arizona Department of Transportation as required by A.R.S. § 28-2051 *et seq.;*
2. Ensure that the facility possesses current insurance coverage for the motor vehicle as required by A.R.S. § 28-4131 *et seq.* The licensee shall maintain proof of current motor vehicle insurance coverage on facility premises and inside each motor vehicle used for transporting enrolled children;
3. Notify the Department by telephone or other equally expeditious means within 24 hours of a motor vehicle accident that occurs while transporting children;
4. Submit a written report to the Department within 7 days of a motor vehicle accident that occurs while transporting children;
5. Not permit an enrolled child to be transported in a truck bed, camper, or trailer attached to a motor vehicle;
6. When transporting enrolled children, use a child passenger restraint system, as required by A.R.S. § 28-907, for each child who is 4 years of age or younger, or who weighs 40 pounds or less;
7. When transporting enrolled children, use an adjustable lap belt or an integrated lap and shoulder belt for each child who is over 4 years of age or who weighs over 40 pounds. A public or private school transporting an enrolled child in a commercial motor vehicle, defined in A.R.S. § 28-1301(1), is exempt from this provision;
8. Equip a motor vehicle used to transport enrolled children with:
   a. A working mechanical heating system capable of maintaining a temperature throughout the motor vehicle of at least 60° F when outside air temperatures are below 60° F;
   b. A working air-conditioning system capable of maintaining a temperature throughout the motor vehicle at or below 86° F when outside air temperatures are above 86° F. A public or private school transporting an enrolled child in a commercial motor vehicle, as defined in A.R.S. § 28-1301(1), is exempt from this provision;
   c. A first aid kit that meets the requirements of R9-5-514(A) and 2 towels or blankets;
   d. Water sufficient for the needs of each enrolled child in the motor vehicle;
9. Maintain a motor vehicle being used to transport enrolled children in a clean condition;
10. Maintain a motor vehicle being used to transport enrolled children in a mechanically safe condition; and
11. Maintain the service and repair records of all motor vehicles that are owned or leased by a licensee for the transportation of enrolled children as follows:
   a. A person operating a single child care facility shall maintain the records for 12 months from the date of an inspection or repair in a single location on facility premises.
   b. A public or private school that uses a school bus as defined in A.R.S. § 28-101 (41) shall maintain records for the school bus as provided in A.A.C. R17-9-108(F).
   c. A school governing board, a charter school, or a person operating multiple child care facilities shall maintain the records for any motor vehicle other than a school bus for 12 months from the date of an inspection or repair in a single administrative office located in the same city, town, or school attendance area as the facility.

B. A licensee shall ensure that an individual who drives a motor vehicle used to transport enrolled children:
1. Is 18 years of age or older. If the motor vehicle driver is a staff member, the staff member shall be a teacher-caregiver;
2. Holds a valid driver's license issued by the Arizona Department of Motor Vehicles as prescribed by A.R.S. § 28-3151 *et seq.*;
3. Carries in the vehicle a list stating the name of each enrolled child being transported and a copy of each child's Emergency, Information, and Immunization Record card;
4. Requires that each door be locked before a motor vehicle is set in motion and remain locked while the motor vehicle is in motion;
5. Requires that each enrolled child remains seated and entirely inside a motor vehicle while the motor vehicle is in motion;
6. Requires that each enrolled child is secured in a seat belt before and while a motor vehicle is in motion. A public or private school transporting an enrolled child in a commercial motor vehicle, defined in A.R.S. § 28-1301(1), is exempt from this provision;
7. Does not permit an enrolled child in a motor vehicle to open or close a motor vehicle door or window;
8. Sets the emergency parking brake and removes the ignition keys from the motor vehicle before exiting the motor vehicle;
9. Ensures that enrolled children are loaded on to or unloaded from a motor vehicle away from moving traffic at curbside, in a driveway, parking lot or other location designated for this purpose; and
10. Does not use audio headphones or a car telephone while a motor vehicle is in motion.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-518. Field Trips

A. A licensee providing a field trip for a child shall:
1. Obtain written permission from a parent before a child participates in a field trip. A field trip permission slip shall include:
   a. The date and purpose of the field trip;
   b. The times of departure from and return to the facility; and
   c. The name, street address, and telephone number, if any, of the field trip destination;
2. Prepare a written field trip plan that is maintained on facility premises and includes the following:

a. The name of each participating child, staff member, and other individuals on the field trip;
b. The times of departure from and return to the facility;
c. The license plate number of any motor vehicle used on the field trip; and
d. The name, street address, and telephone number, if any, of the field trip destination; and

3. Maintain the field trip permission forms and field trip plan on facility premises for 3 months from the date of a field trip.

B. A licensee shall ensure that a staff member taking enrolled children on a field trip carries the following on the trip:

1. A copy of the Emergency, Information, and Immunization Record card of each child participating in the field trip;
2. A list stating the name of each participating child. A staff member shall ensure that each child on the list is present at all times and place a checkmark next to the name of each child present at the following times:
   a. At the beginning of the field trip or when boarding the motor vehicle,
   b. Upon arrival and each hour while at the field trip destination,
   c. When preparing to leave the field trip destination or when boarding the motor vehicle to return to the facility, and
   d. When reentering the facility at the conclusion of the field trip; and
3. Water in an amount sufficient for each participating child during the field trip.

C. A licensee shall ensure that each child participating in a field trip is wearing in plain view a written identification stating the facility's name, address, and telephone number. A licensee shall also ensure that each child is wearing out of view a written identification stating the child's 1st and last names.

D. If a licensee uses a motor vehicle volunteered by a parent or other individual for a field trip, a licensee shall determine before the field trip begins that the motor vehicle is in compliance with R9-5-517(A)(1) and (2) and that the motor vehicle driver is in compliance with R9-5-517(B)(1) and (2).

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-519. Repealed

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Amended Subsection (F) effective July 7, 1988 (Supp. 88-3). Repealed effective October 17, 1997 (Supp. 97-4).

R9-5-520. Repealed

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Repealed effective October 17, 1997 (Supp. 97-4).

R9-5-521. Repealed

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Amended by adding subsection (C) effective July 7, 1988 (Supp. 88-3). Repealed effective October 17, 1997 (Supp. 97-4).

R9-5-522. Repealed

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Amended paragraph (1), subparagraph (e) effective July 7, 1988 (Supp. 88-3). Repealed effective October 17, 1997 (Supp. 97-4).

Table 1. Meal Pattern Requirements for Children

TABLE OF MEAL PATTERN REQUIREMENTS FOR CHILDREN			
Food Components	Ages 1 through 2 years	Ages 3 through 5 years	Ages 6 and Older
Breakfast:			
1. Milk, fluid	½ cup	¾ cup	1 cup
2. Vegetable, fruit, or full-strength juice	¼ cup	½ cup	½ cup
3. Bread and bread alternates (whole grain or enriched);			
Bread	½ slice	½ slice	1 slice
or cornbread, rolls, muffins, or biscuits	½ serving	½ serving	1 serving
or cold dry cereal (volume or weight, whichever is less)	¼ cup or 1/3 oz.	1/3 cup or ½ oz.	¾ cup or 1 oz.
or cooked cereal, pasta, noodle products, or cereal grains	¼ cup	¼ cup	½ cup
Lunch or Supper:			
1. Milk, fluid	½ cup	¾ cup	1 cup
2. Vegetable and/or fruit (2 or more kinds)	¼ cup total	½ cup total	¾ cup total
3. Bread and bread alternates (whole grain or enriched);			
Bread	½ slice	½ slice	1 slice
or cornbread, rolls, muffins, or biscuits	½ serving	½ serving	1 serving
or cooked cereal, pasta, noodle products, or cereal grains	¼ cup	¼ cup	½ cup
4. Meat or meat alternates:			
Lean meat, fish, or poultry (edible portion as served)	1 oz.	1½ oz.	2 oz.
or cheese	1 oz.	1½ oz.	2 oz.
or egg	1 egg	1 egg	1 egg
or cooked dry beans or peas*	¼ cup	3/8 cup	½ cup
or peanut butter, soy nut butter or other nut or seed butters	1 tbsp**	1½ tbsp**	2 tbsp**
or peanuts, soy nuts, tree nuts, or seeds	½ oz.**	¾ oz.**	1 oz.**
or an equivalent quantity of any combination of the above meat/ meat alternates			
Snack: (select 2 of these 4 components)***			
1. Milk, fluid	½ cup	½ cup	1 cup
2. Vegetable, fruit, or full-strength juice	½ cup	½ cup	¾ cup
3. Bread and bread alternates (whole grain or enriched):			
Bread	½ slice	½ slice	1 slice
or cornbread, rolls, muffins, or biscuits	½ serving	½ serving	1 serving
or cold dry cereal (volume or weight, whichever is less)	1/3 cup or ½ oz.	1/3 cup or ½ oz.	¾ cup or 1 oz.
or cooked cereal, pasta, noodle products, or cereal grains	¼ cup	¼ cup	½ cup
4. Meat or meat alternates:			
Lean meat, fish, or poultry (edible portion as served)	½ oz.	½ oz.	1 oz.
or cheese	½ oz.	½ oz.	1 oz.
or egg or yogurt	½ egg or ¼ c	½ egg or ¼ c	1 egg or ½ c
or cooked dry beans or peas*	1/8 cup	1/8 cup	¼ cup
or peanut butter, soy nut butter or other nut or seed butters	1 tbsp	1 tbsp	2 tbsp
or peanuts, soy nuts, tree nuts, or seeds	½ oz.	½ oz.	1 oz .
or an equivalent quantity of any combination of the above meat/ meat alternates			

* In the same meal service, dried beans, or dried peas may be used as a meat alternate or as a vegetable; however, such use does not satisfy the requirement for both components.

** At lunch and supper, no more than 50% of the requirement shall be met with nuts, seeds, or nut butters. Nuts, seeds, or nut butters shall be combined with another meat/meat alternative to fulfill the requirement. Two tablespoons of nut butter or 1 ounce of nuts or seeds equals 1 ounce of meat.

*** Juice may not be served when milk is served as the only other component.

Historical Note

Table 1 adopted effective October 17, 1997 (Supp. 97-4).

ARTICLE 6. PHYSICAL PLANT OF A FACILITY

R9-5-601. General Physical Plant Standards

A. A facility licensed or a licensed facility modified after the effective date of these rules shall conform to the following:

1. Local building and fire codes,
2. Local zoning requirements, and
3. The requirements of A.R.S. § 36-881 *et seq.* and these rules.

B. A facility licensed before the effective date of these rules shall meet the requirements of the local building and fire codes in existence on the date of licensing and any locally required amendments to the building and fire codes.

C. A facility shall not be located in a manufactured home as defined in A.R.S. § 41-2142(24) or a mobile home as defined in A.R.S. § 41-2142(26).

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Amended effective July 7, 1988 (Supp. 88-3). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-602. Supplemental Physical Plant Standards

In addition to complying with the general physical plant standards, a licensee shall comply with the following supplemental physical plant requirements:

A. When a facility is licensed to care for more than 5 infants in an infant room as described in R9-5-502(A)(1), each infant room shall have 2 or more designated exits from the room.

B. Excluding infants and children who use diapers from ratio calculations, toilets, and hand washing sinks accessible to children shall be provided in a facility as follows:
1. At least 1 flush toilet and 1 hand washing sink for 10 or fewer children,
2. At least 2 flush toilets and 2 hand washing sinks for 11 to 25 children, and
3. At least 1 flush toilet and 1 hand washing sink for each additional 20 children.

C. A licensee providing child care services for infants or children who require diapering shall provide a diaper changing area that meets the requirements in R9-5-503 in each infant room or activity area used by an infant or a child who wears diapers or disposable training pants. An applicant or licensee requiring a diaper changing area outside an infant room or activity area to allow privacy for diapering a child with special needs may submit a written request for an approval, and:
1. For an initial application, submit physical plant documents required by R9-5-607 that designate the location of the proposed diaper changing area. The Department shall review the proposed diaper changing area and provide written notice according to the procedures in R9-5-202;
2. For a licensed facility, submit a drawing of the proposed diaper changing area to the Department before installing the diaper changing area. Within 30 days from the date of the receipt of the request the Department shall send written notice to the licensee of approval or disapproval. If the proposed diaper changing area:
   a. Complies with A.R.S. § 36-881 *et seq.* and these rules and provides privacy for the child with special needs, the Department shall approve the proposed diaper changing area; or
   b. Does not comply with A.R.S. § 36-881 *et seq.* or these rules or provide privacy for the child with special needs, the Department shall provide the licensee with the requirements necessary for the Department to approve the requested change; and
3. A licensee shall not use a diaper changing area located outside of an activity area until the Department approves the diaper changing area.

D. A licensee shall ensure that a glass mirror, window, or other glass surface that is located within 36 inches of the floor is made of safety glass that has been manufactured, fabricated, or treated to prevent the glass from shattering or flying when struck or broken, or is shielded by a barrier to prevent impact by or injury to a child.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-603. Facility Square Footage Requirements

A. A licensee shall ensure that the facility meets the following square footage requirements for indoor activity areas based on the classifications of child care services:
1. At least 35 square feet of indoor activity space for each infant and 1-year-old child;
2. At least 25 square feet of indoor activity space for each child who is not an infant or 1-year-old child; and
3. When 1-year-old children are grouped together with children older than 1-year-old children in the same activity area, at least 35 square feet of indoor activity space for each child.

B. When computing indoor activity space for subsections (A)(1) through (3) to determine licensed capacity, the floor space occupied by the following shall be excluded:
1. The interior walls;
2. A kitchen, bathroom, closet, hallway, stair, entryway, office, a room designated for isolating a child from other children, storage rooms, and a room designated for the sole use of child care personnel; and
3. Room space occupied by teacher-caregiver desks, file cabinets, storage cabinets, and hand washing sinks for staff use.

C. A licensee shall provide at least 75 square feet of outdoor activity area for each child occupying the outdoor activity area at any time. To allow scheduled access to an outdoor activity area for each attending child, a licensee shall provide at least 75 square feet of outdoor activity area per child for at least 50% of the facility's licensed capacity.
1. An applicant or licensee may request an exemption from this requirement if:
   a. No enrolled child attends the facility for more than 4 hours per day;
   b. The applicant or licensee provides at least 50 square feet of indoor activity area for each child based on the facility's licensed capacity; and
   c. The applicant or licensee submits a written request for exemption in the narrative portion of the information form.
2. An applicant or licensee may request a substitution of indoor activity area for outdoor activity area if:
   a. The applicant or licensee can provide at least 50% of the outdoor activity area required by this subsection;
   b. The indoor activity area being substituted for outdoor activity area is in addition to the indoor activity area required in subsection (A); and
   c. The applicant or licensee submits a written request to substitute indoor activity area for outdoor activity area in the narrative portion of the information form and identifies on the floor plan the specific location of the indoor activity area being substituted for outdoor activity area.
3. The Department shall review and approve or deny the request for exemption or substitution.
   a. For a request that is part of an initial application, the Department shall review the proposed exemption or substitution and provide written notice according to the procedures in R9-5-202.
   b. For a licensed facility, within 30 days from the date of the receipt of the request, the Department shall review the proposed exemption or substitution and

provide written notice of the review to the licensee. If the proposed exemption or substitution:

i. Complies with A.R.S. § 36-881 *et seq.* and these rules, the Department shall approve the proposed exemption or substitution; or

ii. Does not comply with A.R.S. § 36-881 *et seq.* or these rules, the Department shall provide the licensee with the requirements necessary to approve the requested exemption or substitution.

c. A licensee shall provide at least 75 square feet of outdoor activity area per child for 50% of the facility's license, until the Department approves the exemption or substitution.

4. A licensee shall provide at least 75 square feet of indoor activity area that is substituted for outdoor activity area for each child occupying the activity area.

Historical Note

Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-604. Outdoor Activity Areas

A. A licensee shall provide an outdoor activity area on facility premises.

1. A licensee shall not permit a child to cross a driveway or parking lot to access an outdoor activity area on the facility premises or a school campus unless the licensee obtains written approval from the Department.
2. If a licensee requests approval from the Department for enrolled children to cross a driveway or parking lot to access an outdoor activity area, the Department shall inspect the facility premises or school campus to determine whether the health, safety, or welfare of enrolled children would be endangered. The Department shall notify the licensee of approval or disapproval within 30 days of receipt of the request. If disapproved, the Department shall provide the licensee with the requirements necessary to approve the proposed crossing.

B. Except as provided in subsection (C), a licensee shall ensure that an outdoor activity area:

1. Is enclosed by a fence:
   a. A minimum of 4 feet high;
   b. Secured to the ground; and
   c. With either vertical or horizontal open spaces on a fence or gate that do not exceed 4.0 inches;
2. Is maintained free of hazards; and
3. Has gates that are kept closed while a child is in the outdoor activity area.

C. A licensee shall ensure that a playground used only for school age children at a facility operating at a public or private school meets the fencing requirements of the public or private school. If the Department determines by inspection that a facility fence on a public or private school does not ensure the health, safety, or welfare of enrolled children, the licensee shall meet the fencing requirements of subsection (B).

D. A licensee shall ensure that the following is provided and maintained under swings and climbing equipment in an outdoor activity area:

1. A shock-absorbing rubber unitary surfacing material manufactured for such use in outdoor activity areas; or
2. A minimum depth of 6 inches of a nonhazardous, resilient material such as fine loose sand or wood chips.

E. A licensee shall ensure that hard surfacing material such as asphalt or concrete is not installed or used under swings or climbing equipment unless used as a base for a rubber surfacing.

F. A licensee shall provide a shaded area for each child occupying an outdoor activity area at any time of day.

Historical Note

Adopted effective December 12, 1986 (Supp. 86-6). Amended effective July 7, 1988 (Supp. 88-3). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-605. Swimming Pools

A. If a licensee uses a public or semi-public swimming pool for enrolled children, the swimming pool shall meet the requirements of the swimming pool ordinance enacted by local government. If no ordinance has been adopted, the swimming pool, shall meet the requirements in A.A.C. R9-8-811 through R9-8-852.

B. A licensee that uses a private pool for enrolled children shall ensure that the swimming pool and its equipment meet the following requirements:

1. If a licensee uses a private pool that is a minimum of 2 feet in depth for enrolled children, the swimming pool shall meet the requirements of the swimming pool ordinance enacted by local government and, at a minimum, be equipped with the following:
   a. A recirculation system consisting of piping, pumps, filters, and water conditioning and disinfecting equipment that conforms to the swimming pool manufacturer's specifications for installation and operation, and is adequate to clarify and disinfect the pool water continuously;
   b. Two swimming pool inlets located on opposite sides of the swimming pool to produce uniform circulation of water and maintain uniform chlorine residual throughout the entire swimming pool without the existence of dead spots;
   c. A drain located at the swimming pool's lowest point and covered by a grating that cannot be removed by bathers;
   d. A swimming pool water vacuum system in operating condition;
   e. A removable strainer to prevent hair, lint, or other objects from reaching the pump and filter;
   f. An automatic mechanical water disinfectant system in use and in operating condition. The disinfecting agents shall maintain the swimming pool water as follows:
      i. A free chlorine level between 1.0 and 5.0 parts per million as tested by the diethyl-p-phenylene diamine method or .4 to 1.0 parts per million when tested by the orthotolidine method;
      ii. A pH level between 7.0 and 8.0 as tested by the diethyl-p-phenylene diamine method or the orthotolidine method; or
      iii. A bromine level between 2.0 and 4.0 parts per million as tested by the diethyl-p-phenylene diamine method;
   g. A shepherd's crook; and
   h. A ring buoy attached to a ½ inch diameter rope at least 25 feet in length.
2. If a licensee uses a private pool that is less than 2 feet in depth for enrolled children, the swimming pool shall meet the requirements of subsection (B)(1) except that:
   a. The swimming pool shall have a minimum of 1 swimming pool inlet;

b. The swimming pool is not required to have a bottom drain;
c. A pool water vacuum cleaning system is not required;
d. A ring buoy with attached rope is not required; and

3. A portable pool that does not meet the requirements of subsection (B)(1) or (2) is prohibited.
4. A licensee may add liquid or dissolved dry chemical disinfectants directly to a pool only for shock purposes.
5. A licensee shall maintain a dated, written, daily swimming pool log at the swimming pool site that records the free chlorine, pH ranges and bromine readings, including any actions taken by the licensee to restore the swimming pool chemical ranges required by subsection (B)(1)(f) when out-of-range readings occur. A licensee shall maintain a current swimming pool log on facility premises while the swimming pool for 3 months from the date of use.

C. A licensee that uses a public, semi-public, or private pool for enrolled children shall use only a swimming pool that is enclosed by a wall, fence, or barrier that meets the requirements of a swimming pool barrier ordinance adopted by the local government where the facility is located. If no ordinance has been adopted, the swimming pool shall be enclosed by a wall, fence, or other barrier that meets the requirements of A.R.S. § 36-1681.

D. A licensee that uses any semi-public or private swimming pool for enrolled children shall ensure that the swimming pool has been inspected by the Department or a city or county health department before it is used by enrolled children. If a licensee operates or uses a swimming pool that is inspected by a city or county health department, the licensee shall provide the Department with a current written report of the swimming pool inspection. A licensee shall maintain the current swimming pool inspection reports of a swimming pool used by enrolled children on the facility premises.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Former Section R9-5-605 repealed and a new Section R9-5-605 adopted effective July 7, 1988 (Supp. 88-3). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-606. Fire and Safety

A licensee shall install portable, pressurized fire extinguishers that meet, at a minimum, a 2A-10-BC rating of the Underwriters Laboratories as described in Publication 10 of the National Fire Code, incorporated by reference in A.A.C. R9-1-412. The fire extinguishers shall be installed and maintained in a facility's kitchen and other locations as required by Standard 10-1 of the Uniform Fire Code, incorporated by reference in A.A.C. R9-1-412.

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Amended subsection (A) effective July 7, 1988 (Supp. 88-3). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-607. Required Physical Plant Documents

A. When applying for a license or making a modification to an existing licensed facility, an applicant shall submit to the Department an information form signed by the applicant or licensee containing:
1. The name of applicant;
2. The name, address, and telephone number of facility;
3. The name, address, and telephone number of individual to be contacted if additional information is needed by the Department;
4. The classifications of child care services being requested;
5. The action being requested by the applicant;
6. A brief narrative description of the facility or proposed modification, including the location and assigned age groups of each room in which activities are or will be conducted; and
7. The date the form is submitted to the Department.

B. In addition to the information required by subsection (A), an applicant providing child care services in a facility not located in a public school shall submit to the Department 1 set of final construction drawings including:
1. A site plan drawn to scale showing:
   a. The drawing scale;
   b. The boundary dimensions of the property upon which the physical plant is located;
   c. If more than 1 building is used for the facility, location, and perimeter dimensions of each building;
   d. The location of each driveway on the property;
   e. The location and boundary dimensions of each parking lot on the property;
   f. The location and perimeter dimensions of each outdoor activity area;
   g. The location, type and height of each fence and gate; and
   h. If applicable, the location of swimming pool.
2. A floor plan drawn to scale showing:
   a. The drawing scale;
   b. The length and width dimensions of each activity area used for child care services;
   c. The width of each doorway;
   d. The direction of each door's swing;
   e. The location of each plumbing fixture, including each hand washing, utility, and 3 compartment sink, toilet, urinal, diaper changing area, and drinking fountain; and
   f. The location and type of fire alarm system.
3. A cross section of the physical plant of the facility showing:
   a. Type of construction; and
   b. Materials used in construction.
4. If the physical plant of a facility is larger than 3,000 square feet and is occupied by more than 20 enrolled children and staff members, the seals of an architect, structural engineer, mechanical engineer, and electrical engineer registered as prescribed in A.R.S. § 32-101 *et eq*., verifying compliance with local building and fire codes, local zoning requirements, and the requirements of these rules.
5. If the physical plant of a facility is less than 3,000 square feet and is occupied by less than 20 enrolled children and staff members, a copy of all building or zoning permits or certificate of occupancy issued by the local government to the facility.

C. In addition to the information required by subsection (A)(1), an applicant, providing child care services for children up to school age at a public school, shall submit to the Department 1 set of final construction drawings or 1 school map including:
1. A site plan drawn to scale showing:
   a. The location of each building on the school campus;
   b. The location of each activity area to be used for child care services;

c. The location and perimeter dimensions of each outdoor activity area to be used by enrolled children; and
d. The location, type, and height of the fence surrounding the outdoor activity area.

2. A floor plan drawn to scale showing:
a. The drawing scale;
b. The length and width dimensions of each activity area used for child care services;
c. The width of each doorway;
d. The direction of each door's swing;
e. The location of each hand washing sink, toilet, urinal, diaper changing area, and drinking fountain to be used by enrolled children; and
f. The location and type of fire alarm system.

D. In addition to the information required by subsection (A)(1), an applicant providing child care services only for school-age children in a facility located in a public school, shall submit to the Department a site plan as shown on 2 sets of final construction drawings or 2 school maps of the school campus showing:
1. The location of each school building and outdoor activity area;
2. The location, perimeter dimensions, and age groups of each activity area used by enrolled children;
3. The location of each hand washing sink, toilet, urinal, diaper changing area, and drinking fountain to be used by enrolled children; and
4. The location and dimensions of each outdoor activity area to be used by enrolled children.

E. In addition to submitting the information required by subsection (A)(1), an applicant providing child care services in a facility that is located in a factory-built building as defined in A.R.S. § 41-2142(14) shall also meet the requirements in subsections (B), (C), and (D) for the type of facility providing child care and submit:
1. An installation permit issued by the Arizona Office of Manufactured Housing;
2. One set of final construction drawings that includes the stamp of the Arizona Office of Manufactured Housing;
3. A foundation and tie-down plan for the factory-built building that is prepared and stamped by an engineer registered as prescribed in A.R.S. § 32-101 *et seq.*

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Section repealed; new Section adopted effective October 17, 1997 (Supp. 97-4).

R9-5-608. Repealed

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Repealed effective October 17, 1997 (Supp. 97-4).

R9-5-609. Repealed

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Repealed effective October 17, 1997 (Supp. 97-4).

R9-5-610. Repealed

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Correction to subsection (F) as certified effective December 12, 1986; Amended subsection (A) effective July 7, 1988 (Supp. 88-3). Repealed effective October 17, 1997 (Supp. 97-4).

R9-5-611. Repealed

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Amended effective July 7, 1988 (Supp. 88-3). Repealed effective October 17, 1997 (Supp. 97-4).

R9-5-612. Repealed

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Repealed effective October 17, 1997 (Supp. 97-4).

R9-5-613. Repealed

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Repealed effective October 17, 1997 (Supp. 97-4).

R9-5-614. Repealed

Historical Note
Adopted effective December 12, 1986 (Supp. 86-6). Amended subsection(C) effective July 7, 1988 (Supp. 88-3). Repealed effective October 17, 1997 (Supp. 97-4).

ARTICLE 7. CERTIFICATION OF DAY CARE GROUP HOMES

R9-5-701. Initial certification

A. An individual, partnership, or corporation shall not operate a day care group home unless certified by the Department.

B. A completed, signed and notarized application for certification shall be submitted on forms provided by the Department, along with a non-refundable fee, pursuant to A.R.S. § 36-897.01(C) and (D), and all required attachments. An application submitted on behalf of an individual shall be signed by the individual; an application submitted on behalf of a partnership shall be signed by all partners; an application submitted on behalf of a corporation shall be signed by two officers of the Board of Directors of that corporation. The application shall contain:
1. For each signatory on the application for certification and for all child care personnel, a completed, notarized, work registration card, a completed fingerprint card, and a non-refundable fee covering the cost of the fingerprint check;
2. For corporations, current Certification of Corporation status, a list of the corporate Board of Directors with designated officers, and current bylaws;
3. A floor plan of the proposed facility containing accurate dimensions;
4. A site plan, with accurate measurements, of the facility's surrounding grounds and outdoor activity areas;
5. Name, address and telephone number of available fire, paramedic, emergency room, poison control and police services and the proximity of such services to the facility;
6. Address of any location serving alcoholic beverages within 500 feet of the facility;
7. The addresses of agricultural land within one-fourth mile of the facility;
8. A notarized statement that the certificate holder has sufficient financial resources to maintain and operate the facility in full compliance with the statutes and rules governing day care group homes;
9. Written references, as specified in R9-5-801(B)(13), from persons who are 21 years of age or older and who have personal knowledge of the provider and who will attest to the provider's good character and ability to care for children;
10. Verification of fingerprint registration with the Department, as specified in A.R.S. § 36-897.03, of the applicant,

all personnel, and household members who are 18 years of age or older;

11. Documentation provided by the Department that the provider has attended the Department's orientation program for day care group homes;
12. Copy of report of violation-free fire inspection conducted by the local fire authority or the State Fire Marshal's office. This inspection shall be conducted within 90 days prior to application for certification.
13. Copy of report of sanitation inspection on Department-approved forms conducted within 90 days prior to application for certification; and
14. Copy of report of violation-free gas inspection conducted by a licensed plumber or person licensed by the state to conduct inspection and repairs of gas lines and gas-fired heating and cooling devices conducted within 90 days prior to application for certification.

C. If notified by the Department that the application is not complete, the applicant shall supply the requested information within 15 calendar days after receiving such notice. If the applicant fails to provide the requested information within the stated time, the application shall be denied.

D. After an application for initial certification is determined to be complete, the Department shall conduct an inspection of the facility and its grounds, to determine compliance with statutes and rules governing day care group homes.

E. The applicant shall sign the inspection report acknowledging the receipt of a copy of the inspection report.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted and amended effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted with changes effective October 4, 1990 (Supp. 90-4).

R9-5-702. Certificate to operate a day care group home

A. Upon determination by the Department that the application for certification is complete and the facility is in full compliance with the requirements of Articles 7 through 10 of this Chapter, the Department shall issue a certificate to the provider to operate a day care group home. The certificate shall be valid for three years from the date of issuance and is nontransferable.

B. The certificate is valid only for the certificate holder and location identified on the certificate.

C. The provider shall post the certificate in the day care group home in a location where it can be seen by parents or guardians.

D. Each certificate shall be the property of the state of Arizona and the certificate shall be returned to the Department immediately upon suspension, revocation, expiration of the certificate, or voluntary closure, except for seasonal vacations.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-703. Denial of certification

A. Initial certification to operate a day care group home shall be denied if:

1. Applicant fails to timely submit a properly completed application including required inspections and documents;
2. Applicant provides false, incomplete, or misleading information on the application or during the application process;
3. The applicant fails to allow the Department to enter the day care group home or to inspect required records;
4. The applicant fails to fully comply with statutes and rules governing day care group homes or fails to correct within 30 days deficiencies cited during the initial certification inspection;
5. After the Department has determined that an individual's presence in the facility may be detrimental to children, and after the Department has so notified the applicant, that applicant refuses to exclude said individual from the facility during the hours of operation;
6. Applicant refuses to exclude from the day care group home during hours of operation individuals who have been denied registration pursuant to A.R.S. § 36-897.03;
7. Applicant has been denied a certificate to operate a day care group home or a license to operate a day care center for the care of children for cause, in this state or another state, or has had such a certificate or license to operate a day care group home or day care center revoked, suspended, or not renewed;
8. The Department has determined that the applicant is not of good character conducive to the welfare of children. An applicant who is an individual, or who is the officer of a corporation which is the applicant, or is a partner in a partnership will be considered not to have the good character conducive to the welfare of children if:
    a. The applicant is awaiting trial on, or has been convicted of, or has admitted committing any of the following criminal offenses in this state or similar offenses in another state or jurisdiction:
        i. Sexual abuse of a minor;
        ii. Incest;
        iii. First- or second-degree murder;
        iv. Kidnapping;
        v. Arson;
        vi. Sexual assault;
        vii. Sexual exploitation of a minor;
        viii. Contributing to the delinquency of a minor;
        ix. Commercial sexual exploitation of a minor;
        x. Felony offenses involving distribution of marijuana or dangerous or narcotic drugs;
        xi. Burglary;
        xii. Robbery;
        xiii. A dangerous crime against children as defined in A.R.S. § 36-897.03 or A.R.S. § 13-604.01;
        xiv. Child abuse;
        xv. Sexual conduct with a minor;
        xvi. Molestation of a child;

b. The applicant is the parent or guardian of a child adjudicated to be a dependent child as defined in A.R.S. § 8-201(11);
c. The applicant, at the time of the renewal inspection, is not in full compliance with the statutes and rules governing day care group homes; or
d. During the most recent certification period, the applicant repeatedly operated in violation of statutes and rules governing day care group homes.

B. An application for renewal of a day care group home certificate shall be denied for the reasons specified in subsection (A) of this Section.

Historical Note
Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted and amended effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; editorial corrections to labels of subsections (A)(8)(a)(i) through (A)(8)(a)(xix) (Supp. 89-4). Emergency rule readopted with changes effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted with changes effective October 4, 1990 (Supp. 90-4).

R9-5-704. Renewal of certification

A. An application for renewal of a day care group home certificate shall be submitted on forms provided by the Department no more than 60 days, but not less than 30 days, before expiration of the current certificate. The renewal application shall be accompanied by a non-refundable fee and all required forms and inspection reports specified in R9-5-701(B).

B. When a completed application for renewal of certification is submitted prior to the expiration of the certificate, the existing certification shall remain in effect until the issuance of a final Department decision regarding that application for renewal of certification.

Historical Note
Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-705. Suspension or revocation of certification

Certification may be suspended or revoked for any of the following:
1. Violation of any statute or rule governing day care group homes;
2. Failure to comply with child care personnel registration requirements;
3. Use of personnel for whom proper registration forms have not been submitted or who have been denied registration;
4. Omission of, or refusal to provide, information or records necessary for the Department to determine compliance with statutes and rules governing day care group homes;
5. Fraud or deceit in applying for certification or renewal of certification;
6. Failure to report abuse of a child pursuant to A.R.S. § 13-3620;
7. Failure to allow the Department to enter the day care group home, during the hours of operation, to inspect any record or interview any facility personnel or enrolled children;
8. The presence in the day care group home, during hours of operation, of any personnel or household members:
   a. Who are addicted to drugs or alcohol, or whose performance is affected by the use of drugs or alcohol;
   b. Who have abused any child; or
   c. Who use or have used unacceptable disciplinary methods as defined in R9-5-909(E).

Historical Note
Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-706. Notice of changes

A. The certificate holder shall notify the Department in writing, at least 30 days prior to the effective date, of any of the following changes or physical alterations:
1. Remodeling of the day care group home or its grounds. A copy of the remodeling building permit, if required by the local jurisdiction, shall be attached to the notification of remodeling.
2. Addition of any body of water including wells, cattle tank, swimming pool, spa, hydrotherapy pool, or decorative pond;
3. Modification of records, permits or statements submitted to the Department as a part of the application for certification or renewal of certification; or
4. Transfer of ownership or termination of tenancy of the residence in which the child care services are provided.

B. The certificate holder shall notify the Department, in writing, within 15 days of:
1. Addition or deletion of household members;
2. Voluntary closure of child care services. The provider shall submit the current certificate issued to operate the day care group home along with such notification;
3. Any allegation that personnel or a household member has committed any of the crimes specified in A.R.S. § 36-897.03, or has engaged in or has observed any conduct not conducive to the welfare of the child; or
4. The conviction or arrest of any personnel or household member for any crime specified in A.R.S. § 36-897.03.

Historical Note
Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3).

Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-707. Complaints; investigations

A. Any person may file a written or oral complaint with the Department regarding the operation of a day care group home. The Department shall visit each day care group home as often as necessary to assure continued full compliance with law and the rules.

B. The provider shall allow representatives of the Department to inspect all areas of the day care group home to which the children have access during hours of operation. Such inspection shall include the facility and grounds, required records and reports, interviews with enrolled children, child care personnel and other household members and shall provide access to areas of the facility not used by children but which may affect their welfare or safety.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

ARTICLE 8. DAY CARE GROUP HOME ADMINISTRATION

R9-5-801. Provider standards and responsibilities

A. The provider shall:
1. Be 21 years of age or older;
2. Have a high school diploma or its equivalent;
3. Have current certification in child care first aid and infant/child cardiopulmonary resuscitation through a course approved by the Department; and
4. Have record of attendance from required provider orientation as specified in R9-5-701(B)(11) and all courses, workshops, seminars and training events attended.

B. The provider shall:
1. Orient each of the facility's personnel and each household member to the statutes and rules governing day care group homes and to the facility's policies and procedures;
2. Ensure that the facility is operated in full compliance with statutes and rules governing day care group homes;
3. Ensure that each enrolled child is supervised by child care personnel at all times and that any other duties or activities of personnel shall not interfere with the supervision and care given to children;
4. Ensure that all visitors who are present in the facility or grounds, during hours of operation, are supervised and accompanied by the day care group home personnel;
5. Notify parents and guardians of their right to enter the day care group home, during hours of operation, while their child is present;
6. Maintain a written daily log of all accidents, injuries, behavior problems, or other unusual incidents at the facility. This record shall be kept at the facility for one calendar year following the year in which the incident occurred;
7. Report any unusual incident which has occurred at the facility to the parent/guardian of each enrolled child, including the following:
   a. Illness, injury or death of a child or other person in the day care group home;
   b. Damage to the facility, vehicles, and equipment involved in the provision of child care;
   c. The presence of any individual in the facility who has, or is suspected of having, a contagious or infectious disease transmitted by the fecal oral route, the airborne route or through close personal contact;
   d. An enrolled child who has run away or is missing from the facility;
   e. Any fire at the facility; or
   f. Any occurrence at the facility which required police, fire, ambulance, or other emergency response;
8. Immediately report unusual incidents listed in subsection (B)(7) of this Section to the Department by telephone after they have occurred and shall submit a written report of the incident to the Department within 72 hours of its occurrence;
9. Notify Child Protective Services and the local police immediately if any incident of suspected child abuse is observed, pursuant to A.R.S. § 13-3620;
10. Ensure that back-up personnel, registered with the Department, are available within 15 minutes during hours of operation to assure compliance with staffing requirements specified in R9-5-803. The name, address and telephone number of all available back-up personnel shall be posted by the facility telephone.
11. Develop a written plan and instructions for facility personnel and household members to use in case of emergency. Each of the facility's personnel and household members who are 18 years of age or older shall have read and be able to demonstrate that they can implement the plan.
12. Prior to hiring, make good faith efforts to obtain three personal and three past employer references for facility personnel including household members engaged in child care. These references shall include at least one written personal reference and one written reference from the most recent employer regarding the individual's fitness to provide child care. Documents shall be maintained in the facility which reflect the reference information received.
13. Comply with requirements of R9-5-802(A) and (B).

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted and amended effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-

3). Emergency rule permanently adopted with changes effective October 4, 1990 (Supp. 90-4).

R9-5-802. Personnel standards and responsibilities

A. Personnel providing child care for enrolled children, without direct supervision from the provider, shall:
1. Be 18 years of age or older; and
2. Have a high school diploma or its equivalent.

B. Personnel shall:
1. Be oriented to the statutes and rules governing day care group homes and to facility policies and procedures prior to providing care for enrolled children;
2. Have the physical and emotional health necessary to perform the duties and responsibilities required by the statutes and rules governing day care group homes; and
3. Not use any tobacco products, alcohol, or illegal drugs, or be under the influence of alcohol or illegal drugs while providing child care. When personnel must take medications at the facility, the medications shall be:
   a. Prescribed by a physician in the original container and which do not interfere with the provision of child care; and
   b. Nonprescription medications sold over-the-counter, used as directed and which do not interfere with the provision of child care;
4. Take all reasonable precautions to protect children from hazards;
5. Not cause or permit a child to be abused;
6. Attend nine hours of training each year, which shall include the following:
   a. Orientation of all new employees to the day care group home and its policies and procedures;
   b. On-the-job training for all new personnel who need training in specific areas to meet their job responsibilities;
   c. Personnel responsibilities in complying with these statutes and rules;
   d. Child health and safety procedures including recognition of illness and disease and training in basic disease control techniques;
   e. Child growth and development;
   f. Child abuse prevention, detection and reporting;
   g. Positive guidance and discipline;
   h. Nutrition and good eating habits;
   i. Availability of community services;
   j. Family involvement and communication with families; and
   k. Program planning and development; and
7. Be excluded from the facility if there is evidence that their presence would not be conducive to, or would be detrimental to, the welfare of the children.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted and amended effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-803. Facility staffing

A. One adult personnel member shall be present when one to five children are in care.

B. Two adult personnel staff members shall be present when six to ten children are in care.

C. One additional personnel member shall be present when more than ten children are in care. The personnel member may be a person who is 16 or 17 years old and is directly supervised by the provider.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted with changes effective October 4, 1990 (Supp. 90-4).

R9-5-804. Inspection reports

A. A chronological file of all reports of inspections conducted at the day care group home and documentation that required corrections have been timely made shall be kept current and maintained at the facility.

B. The file of inspection reports shall include all reports issued to the facility by the Department, the Department of Education Child Care Food Program, the Department of Economic Security, any county health department, any fire authority, any department of zoning, inspections conducted by the provider, and any other report issued to the facility by a governmental agency.

C. The file of inspection reports shall be presented to the parent or guardian of each child prior to enrollment at the facility and at any time when requested by the parent or guardian of an enrolled child.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-805. Personnel records and reports

A. The provider shall retain and keep current the following information about child care personnel and all household members:
1. Name, home address, and telephone number;
2. First-aid and CPR certificates, if applicable;
3. Verification of compliance with A.R.S. § 36-897.03;
4. Date of employment or volunteer assignment;
5. Proof of negative tuberculin skin test or chest x-ray for all personnel and household members; and
6. A written statement by the staff member or volunteer, on Department-approved forms, testifying to immunity to

measles, rubella, diphtheria, tetanus and polio. Individuals who were born before January 1, 1957, shall be considered immune to measles and therefore exempt from the measles immunization.

B. Personnel records and reports shall be made immediately available by the provider for inspection by the Department for a period of one calendar year following termination of employment, volunteer work or household membership.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-806. Children's records and reports

A. A day care group home shall maintain at the facility an individual file for each enrolled child separate from household or personal records. The file shall be made immediately available for inspection by the Department and shall contain the following:

1. Child's name, address, sex, and date of birth;
2. Names of the child's parent or guardian, home and work addresses, and telephone numbers;
3. Name, address, and telephone number of individuals to be notified in the event that the parents or guardian cannot be located. A minimum of two emergency contacts shall be available for each enrolled child prior to acceptance to the facility;
4. Name and telephone number of child's primary source of medical care;
5. Authorization and instructions for emergency medical care of the child when the parent or guardian cannot be contacted;
6. Written instructions of the parent, guardian, or attending physician for any special dietary needs;
7. A record completed by the parent, guardian, or physician noting the child's susceptibility to any illness and special needs;
8. Immunization record or exemption affidavit which includes:
   a. A verifiable record provided by the child's health care provider, parent or guardian which states that the child has received current, Department-recommended, age-appropriate immunizations for Haemophilus Influenza, Type B (Hib), measles, mumps, rubella, diphtheria, pertussis, tetanus and polio; or
   b. An affidavit signed by the child's health care provider that the child has a medical condition such that required immunizations would seriously endanger the child's health; or
   c. An affidavit signed by the child's parent or guardian that the child is being raised in a religion which prohibits immunization;
9. Documentation that the provider has given written notice at least quarterly to the parent or guardian of each child who is 24 months of age or younger of all immunizations for that child which will become due during the upcoming quarter;
10. Documentation that the provider has given written notice at least annually, to the parent or guardian of each child who is 25 months or older of all immunizations for that child which will become due during the coming year;
11. Ensure that no child continues enrollment at the day care group home for more than 15 days after receiving notification of necessary immunizations until proof of immunizations or exemption from immunizations is provided;
12. Documentation that the child's parent or guardian was notified immediately of an accident or injury to the child which required police, fire, ambulance or other emergency response;
13. Legal documentation of sole legal guardianship, if the custodial parent or guardian requests that the center not allow the non-custodial parent to interact with the child at the center;
14. Written permission allowing phone authorizations for release of the child signed by the parent or legal guardian;
15. If an enrolled child is to be released to any individuals other than the custodial parent or guardian, authorization for such release shall be obtained when the child is enrolled and shall be updated as changes occur;
16. Name, home and work addresses, and telephone numbers of individuals other than parent or guardian to whom the child may be released; and
17. Written instructions, if any, from the parent or guardian regarding:
    a. Special dietary needs or formula preparation;
    b. Toilet training;
    c. Needs of special children;
    d. Medications routinely taken by the child;
    e. If applicable, permission for the child to participate in water activities; and
    f. If the child is of school age, the name and address of the school attended by the child, the hours of attendance, and a plan for how the child is to go to, and return from, school.

B. Records included in each enrolled child's file shall be written legibly and in English, or if written in another language shall contain an English translation, and shall be retained at least three calendar years after the child is no longer enrolled. Duplicate records may be maintained in the file in another language.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted and amended effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-807. Attendance records; admission and release of children

A. The facility shall keep attendance records, on Department-approved forms, indicating the time of arrival and departure for child care personnel on each day of work. The attendance

record shall be co-signed weekly by the provider and the child care personnel.

B. The provider shall require that the parent or guardian sign an attendance record on Department-approved forms indicating the time of arrival and departure for each enrolled child on each day present. The provider shall also maintain a record of the days and hours that non-enrolled children are present at the facility during hours of operation. All attendance records shall be maintained in the facility for a period of two calendar years.

C. The provider shall require that the parent or guardian designate in writing those individuals 15 years of age and older who are authorized to admit or pick up the child. No child shall be released to a person younger than 15 years of age.

D. The provider shall require that all authorized individuals, other than the parent or guardian, present picture identification prior to releasing the child from the day care group home.

E. A child shall not be admitted to the facility if the child's presence will cause the facility to exceed its certified capacity pursuant to A.R.S. § 36-897(1).

F. No child shall be allowed to admit or release herself from a day care group home unless she is of school age and written authorization is provided by the child's parent or guardian when the child is enrolled. If written authorization is brought to the facility by the child, the authorization shall be verified with the parent or guardian upon receipt.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted and amended effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-808. Insurance

A. The applicant or the certificate holder shall secure and maintain general liability insurance covering the enrolled children with minimum limit of $100,000. Providers who obtain commercial insurance coverage shall be required to have a Certificate of Insurance. If the liability insurance coverage includes a waiver of coverage for physical or sexual abuse, the parents shall be notified at the time of enrollment.

B. The certificate holder shall obtain and maintain motor vehicle insurance coverage in accordance with A.R.S. § 28-1101 *et seq.*, Uniform Motor Vehicle Safety Responsibility Act, for vehicles used to transport enrolled children.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-809. Other businesses on facility premises

No other business shall be conducted at the facility or on the grounds of the facility designated for use by enrolled children during the hours of operation.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

ARTICLE 9. PROGRAM AND EQUIPMENT FOR DAY CARE GROUP HOMES

R9-5-901. General program and equipment standards

A. The day care group home shall maintain a safe and healthful environment, free from disease and illness.
1. Personnel shall not at any time endanger the health or safety of the children under their care; and
2. Personnel shall ensure that each child is clean and groomed as necessary after meals and activities.

B. The day care group home shall provide a program which includes a balance of daily activities which meet the age interests and developmental needs of each child including:
1. Indoor/outdoor activities;
2. Quiet/active activities;
3. Supervised free choice/adult-directed activities;
4. Individual, small group and large group activities;
5. Small/large muscle development activities; and
6. Meals and snacks.

C. Daily routine activities for each child, including diapering, toileting, eating, dressing, resting, and sleeping shall be incorporated into the program based upon developmental needs of the child.

D. The program shall be adjusted to the needs of children, to cope with illness, changes in weather or other situations.

E. If swimming is offered as a part of the facility's program, child care personnel shall be stationed at the pool when the pool is being used by children. At least one of the child care personnel present at the pool shall be able to swim, and one of the personnel present at the pool shall be currently certified in cardiopulmonary resuscitation. Personnel shall be able to see clearly all parts of the pool including the bottom.

F. Each day care group home shall have sufficient play materials and equipment so that, at any one time, each child who is present can be individually involved in the activities outlined in the activity plan.

G. In addition to requirements specified in this rule, a day care group home providing care for three-, four- and five-year-old children shall provide the following play materials and supplies:
1. Art supplies,
2. Blocks and block accessories,
3. Books and posters,
4. Dramatic play areas with toys and dress-up clothes,
5. Large muscle equipment,
6. Manipulative toys,
7. Science materials, and
8. Musical instruments.

H. The facility shall make the following provisions for sleeping children:
1. There shall be a separate bed, cot, floor mat, or crib for each child who needs to nap or rest. Bunked beds are not permitted unless the child sleeps on the bottom bed. No other individual shall nap or rest on the bed, cot, mat or crib which is being used by an enrolled child;
2. An enrolled child shall not nap or sleep on a bed of a household member;
3. Beds, cots and cribs shall be of sound construction, of sufficient size to comfortably accommodate the size and weight of the child, and shall be kept clean and in good repair;
4. Mats shall be covered with waterproof material and used only in rooms where close contact with the floor will not bring the sleeping child in contact with draft or dust;
5. Rugs, carpet, blankets, and towels shall not be used as mats;
6. Each bed, cot, or floor mat shall be completely covered with a clean sheet or similar covering which shall be laundered weekly or more frequently as needed. Coverings shall be freshly laundered before use by another child.

I. No enrolled child shall be locked out of the facility with any locking device.

J. An enrolled child shall never be placed on a waterbed.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted and amended effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted with changes effective October 4, 1990 (Supp. 90-4).

R9-5-902. Supplemental program and equipment standards for infants and children two years of age and younger

A facility which provides child care to enrolled infants and children two years of age or younger shall comply with the following:
1. Child care personnel shall talk to and hold children two years of age and younger frequently throughout the day;
2. Child care personnel shall respond promptly to the infant's and child's distress signals and need for comfort;
3. Infants and children shall spend no more than one hour of consecutive time during waking hours confined in a crib, playpen, high chair or other confining structure or piece of equipment;
4. Each infant and child shall be allowed to maintain individual pattern of sleeping, waking and eating, unless instructed by the parent or guardian in writing to the contrary;
5. Formulas prepared by the provider shall be prepared and stored in accordance with written instructions of the infant's parent or guardian;
6. Infants six months of age or younger, or children who cannot hold their own bottles, shall be held by child care personnel while being fed. Bottles shall never be propped;
7. Bottles shall be individually labeled and properly stored;
8. Plastic bottle liners shall not be reused. Used bottles shall be promptly removed from cribs or beds, emptied and cleaned;
9. Only water shall be used in bedtime or nap-time bottles;
10. Children shall not be fed cereal by bottle;
11. Each infant's or child's diaper shall be checked frequently and changed as soon as wet or soiled;
12. The provider shall consult with the parent or guardian to establish a mutual plan regarding individual toilet training and shall not force toilet training on any child;
13. A sturdy adult-size chair shall be provided in the infant room for personnel to use when holding and feeding infants;
14. Highchairs shall be equipped with a safety strap and constructed so that the chair will not topple. A safety strap is not required if the design and construction of the chair is such that a safety strap is not necessary. All surfaces shall be smooth, free of cracks, and shall be sanitized prior to each use;
15. A crib of sturdy construction with bars spaced no more than 2 3/8 inches apart shall be available for each infant. Stacked cribs are not permitted;
16. Crib mattresses shall be completely and tightly covered with waterproof material. If plastic materials are used, they shall be durable and safe for children. Plastic bags shall not be used for mattress covers;
17. There shall be no restraining devices of any type used in cribs;
18. Each crib shall have clean, crib-size bedding, including sheets and a blanket which is in good repair;
19. Each crib and mattress shall be cleaned and bedding changed daily, or more often if necessary, and always before use by another child;
20. Materials and equipment meeting the interests and needs of infants and one- and two-year-olds shall include:
    a. Books, including some cloth books;
    b. Medium-size rubber or soft plastic balls;
    c. Manipulative toys;
    d. Blocks and block accessories;
    e. Washable soft toys, stuffed animals and dolls;
    f. Large muscle equipment; and
    g. Musical instruments; and
21. Toys to be used by one- and two-year-old children shall be durable, clean, movable, nontoxic, too large to swallow, and have no sharp pieces, edges or points. Toys shall be inspected frequently and regularly to ensure they are not hazardous.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted and amended effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted with changes effective October 4, 1990 (Supp. 90-4).

R9-5-903. Supplemental equipment standards for school-age children

In addition to materials and supplies specified in R9-5-901(G), the day care group home shall provide play materials and equipment

that meet the interests and developmental needs of children including:

1. Arts and crafts,
2. Games,
3. Sports equipment,
4. Books,
5. Science materials, and
6. Manipulative toys.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-904. Supplemental program and equipment standards for special needs children

A. The provider may enroll special needs children when the following conditions are met prior to the child's attendance:

1. Documented training or consultation is obtained to enhance the ability of the personnel to meet the individual needs of enrolled special needs children;
2. Activities and equipment substitutions are available or necessary activity and equipment adaptations are made to meet the requirements of enrolled special needs children;
3. Modifications are made to the home environment which accommodate the individual needs of special needs children;
4. The Department may require a higher number of adults to supervise special needs children than is specified in R9-5-803 in order to meet their needs; and
5. Prior to the child's enrollment, a conference shall be held between the parent or guardian and the provider, to determine and document the needs of the special needs child. When necessary, and with prior written authorization from the parent or guardian, the provider shall also consult with other qualified individuals regarding the care to be provided to the special needs child.

B. Personnel should be familiar with appropriate community resource referral services and shall inform the parent or guardian of them.

C. Special needs children shall be integrated into the daily activities of the day care group home whenever possible within the least restrictive environment that meets the individual needs of special needs children in attendance.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-905. Supplemental program and equipment standards for night care

After consultation with the parent or guardian to establish a written plan regarding night home care, a day care group home providing night home care shall comply with the following:

1. The facility shall provide each infant with a crib which meets the requirements of R9-5-902(A)(15) through (19), and each child with an individual, comfortable bed that is not less than a sturdy cot;
2. Enrolled children shall be bathed or showered at the facility only with written permission of parent or guardian;
3. If enrolled children are bathed at the facility, the bathtub or shower shall be sanitized between uses;
4. Facility personnel who provide evening and night child care for enrolled children shall remain awake until all children are asleep;
5. During night home care, personnel may sleep only if they maintain unobstructed access to the sleeping enrolled children and unimpaired hearing of them. Personnel or household members shall not share the same bed with an enrolled child;
6. An enrolled child shall not sleep in a bed used at other times of the day or night by household members.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted with changes effective October 4, 1990 (Supp. 90-4).

R9-5-906. Illness and infestation

A. Each child shall be observed daily by personnel for signs of illness and infestation upon entry to the facility.

B. The provider shall not accept or allow a child to remain at the day care group home if the child shows symptoms of inflammation, fever, rash, diarrhea, vomiting, pinworms, lice, or is suspected of having a contagious or infectious disease or infestation.

C. If the child develops symptoms of illness or infestation while at the day care group home, personnel shall isolate the child from others upon discovery and shall immediately notify the child's parent or guardian to arrange for prompt removal of the child.

D. The provider shall notify the parent or guardian in writing within 24 hours if the child has been exposed to a contagious disease or infestation. In addition, the facility shall notify the local health department of all contagious diseases within 24 hours.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days

(Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-907. Emergency medical care

A. The provider shall immediately notify the child's parent or guardian or the person specified by the parent or guardian to be notified in case of an emergency or serious injury to the child which requires medical attention.

B. A first-aid kit shall be maintained in the day care group home which is accessible to all personnel but out of the reach of children. The first-aid kit shall contain at a minimum:
1. Adhesive bandages,
2. Antiseptic solution,
3. Sterile bandages,
4. Scissors,
5. Medical tape,
6. Cotton swabs, and
7. Syrup of ipecac within expiration limits.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted and amended effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-908. Medications

A. The provider shall develop a medication policy and notify parents or guardians of the policy.

B. Before medications are administered, the provider shall develop procedures which adhere to the following:
1. Staff designated by the provider in writing shall be responsible for the administration of medication including the storage, recordkeeping, handling and overseeing the child's ingestion or application of medication. Only one staff member in the day care group home at any given time shall be designated for administration of medication;
2. Staff shall not administer medications to a child without specific written authorization from the child's parent or guardian. Such authorizations shall contain at least the following information:
   a. The name of the child;
   b. The name and prescription number of the medication to be given;
   c. Specific instructions for administering the medication including the dosage, method of administration, the dates and time of day medication is to be given;
   d. Reason the medication is being given;
   e. Signature of parent or guardian; and
   f. Date of authorization; and
3. Injections shall be administered only by individuals licensed to do so by the state;
4. The provider shall maintain a record of all medications administered to each child by day care group home staff. The record shall contain:
   a. The name of the child;
   b. The name and prescription number of the medication;
   c. The date and time, dosage, and method by which the medication was administered; and
   d. The signature of the staff member who administered the medication;
5. The provider shall administer only medications that are provided by the parent or guardian in the original container and are labeled with the individual child's full name;
6. Medications which have expired or are no longer to be administered shall be returned to the child's parent or guardian within 24 hours;
7. All prescription and nonprescription medications shall be kept in a locked storage cabinet or in a locked container which is located out of the reach of children;
8. Medications requiring refrigeration shall be kept in a locked, leakproof container in the refrigerator;
9. The provider shall not keep stock supplies of any prescription or nonprescription medication.

C. Medication records shall be maintained for three years and shall be available in the facility for immediate inspection by the Department.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted with changes effective October 4, 1990 (Supp. 90-4).

R9-5-909. Discipline and guidance

A. Disciplinary measures shall meet the child's age, intellectual development and emotional needs. All discipline shall be used to teach a child acceptable behavior, not as punishment or retribution.

B. Facility personnel shall define and maintain consistent, reasonable rules and set limits for children and shall model and encourage acceptable positive behavior.

C. A child whose behavior is uncontrolled may be restrained by being firmly held by day care personnel only when all of the following conditions apply:
1. It is necessary to prevent harm to the child or others,
2. It occurs simultaneously with the uncontrolled behavior,
3. It does not impair the child's breathing, and
4. Personnel shall use only the amount of restraint necessary to bring the behavior under control.

D. A child may be isolated from other children for unacceptable behavior but shall be kept in full view of child care personnel for periods not longer than three minutes after the child regains composure. Under no circumstances shall a child be isolated for more than ten minutes. No child may be isolated or locked into any closet, laundry room, garage, shed, structure, or room.

E. Disciplinary and guidance techniques and methods shall not be used which are:
1. Detrimental to the health or emotional needs of the child,
2. Humiliating or frightening to a child,
3. Corporal punishment,

4. Associated with eating, napping or toileting,
5. Medications or mechanical restraints and devices, or
6. Administered or performed by other children.

F. If the children of the provider or facility personnel receive discipline inconsistent with that specified above, the discipline may not be performed in the presence or hearing of the enrolled children.

G. Only day care group home personnel shall be allowed to discipline an enrolled child.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted and amended effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted with changes effective October 4, 1990 (Supp. 90-4).

R9-5-910. Nutrition and meals

A. The provider shall serve foods which meet the nutrition standards specified in this Article.

B. A varied menu of foods from within each food group shall be served.

C. The provider shall maintain at the facility a one-day supply of perishables and a three-day supply of staples.

D. The provider shall maintain records showing that quantities of food purchased, prepared, and served meet minimum nutritional requirements. Acceptable records include the federal Child Care Food Program production sheets, food receipts, and purchasing logs.

E. Second servings of foods shall be made available to children in addition to the required daily minimum.

F. Minimum meal components and serving sizes to meet calorie and nutrient requirements for various ages of children, as established by the National Research Council Recommended Daily Allowances (RDA), shall be as prescribed in the following table:

TABLE OF MEAL PATTERN REQUIREMENTS FOR CHILDREN

Food Component	Ages 1-3	Ages 3-6	Ages 6-15
	Breakfast		
1. Milk (fluid)	1/2 cup (4 oz)	3/4 cup (6 oz)	1 cup (8 oz)
2. Vegetables/fruits or	1/4 cup	1/2 cup	1/2 cup
juice (full-strength)	1/4 cup (2 oz)	1/2 cup (4 oz)	1/2 cup (4 oz)
3. Bread or	1/2 slice	1/2 slice	1 slice
biscuits, rolls, muffins, etc, or	1/2 serving	1/2 serving	1 serving
cold dry cereal or	1/4 cup	1/3 cup	3/4 cup
cooked cereal or grains or	1/4 cup	1/4 cup	1/2 cup
cooked pasta or noodle products	1/4 cup	1/4 cup	1/2 cup
	Lunch/Supper		
1. Milk (fluid)	1/2 cup (4 oz)	3/4 cup (6 oz)	1 cup (8 oz)
2. and 3. Vegetable(s) and/or fruit(s) (from two sources)	1/4 cup	1/2 cup	3/4 cup
4. Bread or	1/2 slice	1/2 slice	1 slice
biscuits, rolls, muffins, etc. or	1/2 serving	1/2 serving	1 serving
cooked pasta or noodle products or	1/4 cup	1/4 cup	1/2 cup
cooked cereal or grains	1/4 cup	1/4 cup	1/2 cup
5. Meat (lean) or	1 oz	1 1/2 oz	2 oz
poultry or fish or	1 oz	1 1/2 oz	2 oz
eggs or	1	1	1
cooked dry beans, peas lentils or	1/4 cup	3/8 cup	1/2 cup
peanut butter or	2 T	3 T	4 T
cheese	1 oz	1 1/2 oz	2 oz
	Snacks		
Select 2 of the following 4 components			
1. Milk (fluid)	1/2 cup (4 oz)	1/2 cup (4 oz)	1 cup (8 oz)
2. Vegetables/fruits or	1/2 cup	1/2 cup	3/4 cup
juice (full-strength) (except with milk)	1/2 cup (4 oz)	1/2 cup (4 oz)	3/4 cup (6 oz)
3. Bread or	1/2 slice	1/2 slice - 1 slice	
biscuits, rolls, muffins, etc. or	1/2 serving	1/2 serving	1 serving
cold dry cereal or	1/4 cup	1/3 cup	3/4 cup
cooked cereal or grains or	1/4 cup	1/4 cup	1/2 cup
cooked pasta or noodle products	1/4 cup	1/4 cup	1/2 cup
4. Meat (lean) or	1/2 oz	1/2 oz	1 oz
poultry or fish or	1/2 oz	1/2 oz	1 oz
cheese or	1/2 oz	1/2 oz	1 oz
eggs or	1/2egg	1/2egg	1 egg
cooked dry beans, peas lentils or	1/8 cup	1/8 cup	1/4 cup
peanut butter or	1 T	1 T	2 T
peanuts	1/3 cup	1/3 cup	2/3 cup

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-911. General food service and food handling standards

A. Children and staff shall wash hands with soap and warm running water before handling, serving or eating food. Handwashing with washcloths shall be restricted to infants and special needs children.

B. Children shall be encouraged but not forced to eat.

C. Children shall be given necessary assistance in feeding and taught self-feeding skills.

D. The provider shall supply individual drinking and eating utensils and food for each child. Each child shall have an individual, marked bottle, cup or glass and shall not be allowed to drink from bottles, cups or glasses of children or other individuals.

E. All utensils or equipment used for eating, drinking and food preparation shall be washed in hot water and sanitized either by hand or in an automatic dishwasher after each use or single-use disposable tableware shall be used.

F. All perishable foods including those in sack lunches shall be covered and stored in a refrigerator at temperatures of 45 degrees F. or less.

G. Children shall not be allowed to eat food directly off the floor, carpet or ground.

H. The child's parent or guardian shall be notified when a child consistently refuses to eat or exhibits unusual eating behavior.

I. Meals prepared by the provider or individual sack lunches supplied by the parent or guardian shall be served to children at customary meal times.

J. The provider shall not serve the same menu twice in the same day.

K. Fresh milk shall be served directly from the original, commercially filled container. Unused portions of individual servings shall not be returned to the original container or stored for future consumption.

L. Reconstituted dry milk shall not be served to enrolled children to meet the fluid milk requirement.

M. Foods shall be prepared as close to serving time as possible to protect children and personnel from food-borne illnesses.

N. Foods shall be prepared in a manner to maintain nutrients, proper temperature, flavor, texture, and appearance.

O. No spoiled food shall be served but shall be discarded as organic waste in the manner specified in these rules.

P. The provider shall serve milk or full-strength unsweetened juice to children whose sack lunches do not include these items.

Q. Juices served to children for meals and snacks shall be full-strength vegetable or fruit juice from a can, carton or concentrate. Imitation, powdered, syrup, or concentrated drinks, ades or punches shall not be used in place of full-strength juices.

R. Menus shall specify foods to be served and shall be planned at least one week in advance, dated and posted prior to the day of service.

S. Menu substitutions shall be written on the posted menu no later than the morning of the meal service.

T. When a child requires a modified diet prescribed by the parent, guardian or physician, the provider shall inform personnel of the diet restrictions and serve food that complies with the prescribed dietary regimen.

U. Children shall receive the following meals or snacks when at the facility for the time periods specified below:

1. For two to four hours, one or more snacks shall be served unless the child is at the facility during a regular meal time, in which case the child shall be served meals which meet the requirements outlined in R9-5-910;
2. For four to eight hours, a meal and one or more snacks shall be served;
3. For nine or more hours, two snacks and one or two appropriate meals shall be served;
4. A snack shall be served before bedtime;
5. Breakfast shall be available to children who are scheduled to be in attendance at the facility before 8:00 a.m.;
6. Lunch shall be served to children who are at the facility between 11:00 a.m. and 1:00 p.m.; or
7. Dinner shall be available to children who are at the facility from 5:00 p.m. to 7:00 p.m., or upon parent or guardian request.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted and amended effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-912. Transportation of children and field trips

A. Prior to transporting enrolled children for any reason, the provider shall obtain written authorization from the child's parent or guardian.

B. Vehicle and driver requirements:

1. The vehicle shall be maintained in a mechanically safe condition which shall be verified by the provider's vehicle maintenance records;
2. Vehicle drivers for enrolled children shall be 18 years of age or older, hold a current and valid Arizona driver's license and a current first-aid and cardiopulmonary resuscitation certificate;
3. Persons with a suspended driver's license or with a record of arrest or conviction for DWI within the past three years shall not transport enrolled children;
4. Children shall not be transported in vehicles which are not constructed for the purpose of transporting people such as truck beds, campers or any trailered attachment to a motor vehicle;
5. All children shall be seated on seats which are securely fastened to the body of the vehicle and which provide sufficient space for the child's body;
6. Seat belts or child restraint devices shall be required of all children when they are transported in a vehicle which weighs under 10,000 pounds Gross Vehicle Weight (GVW). In addition, children four years of age or younger and weighing 40 pounds or less must be properly secured in a child safety seat;
7. No personnel or child shall stand or sit on the floor while vehicle is in motion;
8. Vehicles used to transport children shall have operable heating and air conditioning; and
9. A first-aid kit which meets requirements specified in A.A.C. R9-5-907(B) and two large clean towels or blankets shall be maintained in each vehicle.

C. Transport safety requirements:

1. The provider shall immediately notify the Department of any traffic accident involving children being transported by the provider and submit a written accident report to the Department within five working days on Department-

approved report forms along with the copy of any police report pertaining to the accident;
2. No child shall be allowed to open or close doors of vehicles transporting enrolled children;
3. Headphones or earphones shall not be worn by the driver of a vehicle while transporting enrolled children;
4. The provider shall maintain a safe vehicle loading and unloading area for children which is located away from any hazard;
5. When away from the facility, the vehicle shall be parked at curbside to load and unload children. When a curbside location is not available, an adult shall find or make a safe path for children to enter or exit the vehicle prior to loading and unloading;
6. The vehicle driver shall remove the keys from the vehicle and set the emergency brake before exiting the vehicle;
7. Vehicle doors shall remain locked at all times when the vehicle is in motion; and
8. A child shall not be left unattended in a vehicle.

D. Field trip requirements.
1. The provider shall obtain written permission from the parent or guardian in advance of the child's participation in a field trip. The field trip permission notice shall provide details of the trip including the purpose of the field trip, time of departure and arrival at the day care group home, and the address of the trip destination;
2. A copy of the emergency information record for each child participating in the field trip shall be taken on all field trips;
3. Sufficient water or other beverages shall be available to children as necessary for the entire trip; and
4. Each child shall have on his person, in plain view, the provider's name, address, and telephone number. The child's first and last name shall be placed inconspicuously on his person.

Historical Note

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ARTICLE 10. ACTIVITY AREAS AND PHYSICAL FACILITY STANDARDS FOR DAY CARE GROUP HOMES

R9-5-1001. Day care group home activity areas

A. There shall be at least 30 square feet of open floor space in the indoor activity area for each child in the facility which shall not include single-use areas such as kitchens, family bedrooms, bathrooms, laundry rooms, shop areas, or garages.

B. Rooms used by enrolled children shall be maintained at temperatures between 68 degrees Fahrenheit and 82 degrees Fahrenheit.

C. The facility shall have indoor bathroom facilities, with a toilet and sink available for each ten individuals in the facility, including children, facility personnel, and household members.

D. An outdoor activity area shall be available to children which:
1. Provides at least 80 square feet of activity space for each child;
2. Includes shaded areas large enough to accommodate each child using the area at any one time;
3. Is accessible by a safe route;
4. Is easily accessible to the indoor activity area and to bathroom facilities;
5. Provides play equipment which is in good repair;
6. Is arranged to eliminate hazards and minimize conflict with other activities;
7. Has both hard surfaces and grass or other resilient surface. Resilient surfaces shall at least extend four feet from climbing structures in every direction, five feet from the bottom of a slide, seven feet plus the length of a swing's chain from the point of its suspension and seven feet from a merry-go-round or other revolving device; and
8. Shall be free of all hazards and totally enclosed by a secure fence which is at least four feet high. Open spaces between upright or parallel posts and poles on fences and gates shall not exceed four inches. Gates shall be equipped with a self-closing latch and kept closed but not locked during hours of operation.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted and amended effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-1002. Swimming pools

A. All swimming pools and equipment shall conform to manufacturer's specifications for installation and operation and shall be maintained and operated in a safe and sanitary manner at all times.

B. Swimming pools over two feet deep shall have the following:
1. A recirculation system including at least one removable strainer, two pool inlets placed on opposite sides of the pool, and one drain located at the pool's lowest point covered by a grating designed to prevent suction of body surfaces;
2. A vacuum cleaning system; and
3. Two ring buoys, one of which has a minimum of 25 feet of 1/2-inch rope attached and a shepherd's crook.

C. Pools two feet deep or less shall meet the requirements of subsection (B) except:
1. The recirculation system shall have at least one pool inlet and bottom drain is not required,
2. No vacuum cleaning system is necessary, and
3. No ring buoy is necessary.

D. Swimming pools shall be enclosed by a fence which separates it from all other outdoor areas with a minimum height of five feet and a self-closing and self-latching, lockable gate. Open spaces between upright or parallel posts and poles on fences and gates shall not exceed four inches. The gate shall be kept locked whenever the pool is not in use.

E. If a community or neighborhood swimming pool is accessible to enrolled children, the swimming pool shall be enclosed by a fence of at least five feet in height with self-closing and self-

latching gates. Open spaces between upright or parallel posts and poles on fences and gates shall not exceed four inches. If these requirements are not met, the outdoor play area of the facility shall be entirely fenced as specified in R9-5-1001(D)(8).

F. The provider shall ensure that all pool drain grates are in place, are in good repair, and cannot be removed without using tools.

G. The provider shall ensure that pool chemicals are in a locked storage area which is inaccessible to the children and that machinery rooms are locked.

H. Residential hot tubs, spas, ponds, and portable wading pools shall not be accessible to, or used by, enrolled children.

Historical Note

Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted and amended effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-1003. Fire and safety

A. An annual fire safety self-inspection shall be conducted by the provider. The inspection findings shall be recorded on Department-approved forms, and a copy of the report shall be timely submitted to the Department. In local fire districts requiring annual inspections by that fire authority, the provider shall also submit to the Department a copy of the local annual fire inspection report.

B. Smoke detectors shall be installed in all sleeping areas and hallways of the residential facility and shall be maintained in operable condition.

C. Smoke detector batteries shall be tested monthly. A record of the test shall be kept at the facility and shall be available for inspection.

D. Portable fire extinguishers which are approved by the State Fire Marshal shall be installed in the kitchen and in the activity areas primarily used for child care. Disposable fire extinguishers shall be discarded when the indicator reaches the red zone and all rechargeable extinguishers shall be serviced annually. The current inspection tag shall be attached to each fire extinguisher.

E. An evacuation plan shall be conspicuously posted and fire evacuation drills shall be held at least once a month at varying times of the day.

F. At least two unobstructed, usable exterior exits shall be available to enrolled children.

G. Enrolled infants and children under the age of seven years shall not be cared for below or above the facility's ground level unless there is an exit directly to the outside at that level.

H. The facility, and facility grounds which are accessible to enrolled children, shall be designed, constructed and maintained in good repair and kept free of hazards.

I. Furnishings, equipment, supplies, materials, utensils, toys and facility grounds shall be maintained in a safe and sanitary condition.

J. Firearms and ammunition shall be stored in a locked area, locked cabinet, or locked container inaccessible and out of view of children.

K. Stairways to levels or rooms not to be used by enrolled children shall be separated either by a door or gate which shall be kept closed during hours of operation.

L. Low glass windows, sliding doors, or other glass partitions shall either be made of tempered glass or have protective markings or other designation at a child's eye level.

M. At least one telephone which is not a pay telephone shall be readily available in the facility with emergency telephone numbers conspicuously posted on or beside it. These phone numbers shall include police, fire, 9-1-1, poison control, and the facility's telephone number and address.

N. All toxic and corrosive materials shall be kept in locked storage areas, cabinets, or containers;

O. Electrical outlets shall be covered when not in use. All appliances, lights, other items, or devices with frayed electrical cords shall be repaired, discarded, or stored in a locked area.

P. Extension cords shall not be used in place of permanent wiring. Electrical cords shall not hang in sight or in reach of children.

Q. Unused natural gas outlets shall have the valves removed and shall be capped at the wall or floor.

R. Gas lines shall be inspected and serviced as needed by a qualified professional but at least annually.

S. Heating and cooling equipment shall not be accessible to enrolled children. Unvented or open-flame space heaters and electric portable heaters shall not be used.

T. All fireplaces shall be screened.

U. Fans shall be permanently mounted and placed out of reach of enrolled children.

V. The day care group home and its grounds shall be well illuminated.

W. Children shall not be allowed to play with ropes or on rope swings.

X. Poisonous plants shall be inaccessible to enrolled children.

Y. All irrigation ditches, abandoned mines, and wells shall be inaccessible to children.

Historical Note

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R9-5-1004. Sanitation

A. An annual sanitation inspection shall be conducted on Department-approved forms, a copy of which is to be submitted to the Department.

B. The facility, furnishings, equipment, materials, and toys shall be kept clean and free of insects and vermin.

C. An individual clean space shall be provided for each child's personal toothbrush, comb, washcloth, extra clothing, blanket, etc. Each child's toilet articles shall be separated from the articles used by other children.

D. All equipment, toys, and materials used by, or accessible to, enrolled children shall be maintained in a clean and usable condition and disinfected as necessary. Fabric toys and toys for enrolled children who are 30 months of age and younger shall be washed and disinfected at least weekly.

E. Drinking water shall be available to enrolled children at all times.
F. Insect control shall include screening of all direct openings to the outside. Doors which open to the outside shall not be left open without insect control.
G. There shall be covered, lined, waterproof, easily cleaned containers for the storage of soiled clothing. The children shall not have access to the containers.
H. All plumbing fixtures shall be maintained in proper operating condition. There shall be sufficient water pressure at all times to meet the needs of the facility.
I. In each bathroom at the facility to be used by enrolled children, mounted toilet tissue, soap, and mounted, singly dispensed paper towels shall be available at all times and within easy and safe reach of children.
J. Toilet bowls, urinals, lavatories, tubs and showers, drinking fountains, and the bathroom, playroom, and kitchen floors shall be scrubbed with a disinfectant cleaning solution as needed but not less than daily.
K. Organic waste shall be disposed of immediately in a sanitary manner and stored in tightly covered containers lined with plastic bags and secured with tight-fitting covers.
L. Garbage, trash and organic waste shall be placed in secured plastic bags and removed from the facility daily, or more often if necessary, to maintain a sanitary environment.
M. Tightly covered outdoor containers for garbage and trash, consistent with existing residential codes, shall be available in sufficient quantity to accommodate all waste products. Removal of waste products from the facility and its grounds shall be scheduled to maintain freedom from odor, vermin, and insects and to prevent the intrusion of animals.

Historical Note
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R9-5-1005. Diaper changing
A. The diaper changing area shall not be located in the kitchen or eating areas and shall be accessible to soap and warm running water.
B. The diaper changing surface shall be cleaned, sanitized, and dried before and after each diaper change.
C. Personnel shall wash their hands with soap and warm running water before and after each diaper change.
D. Soiled cloth diapers shall not be rinsed but shall be individually bagged in plastic and stored in a covered container out of reach of children. Soiled disposable diapers shall be discarded into tightly covered lined containers which are inaccessible to children.

Historical Note
Adopted as an emergency effective July 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days; Emergency rule readopted effective September 28, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency rule readopted effective December 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency rule readopted effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. Emergency rule readopted effective July 9, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency rule permanently adopted effective October 4, 1990 (Supp. 90-4).

R9-5-1006. Pets and animals kept on the premises
A. The provider shall be responsible for the behavior, maintenance, and cleanliness of pets or other animals at the facility or on the grounds of the facility when enrolled children are present.
B. All dogs at the facility or on the grounds of the facility shall be vaccinated against rabies.
C. Pets shall be controlled to assure that proper sanitation at the facility or on the grounds of the facility is maintained and to assure that the animals are not a hazard to enrolled children, personnel, or visitors at the facility.
D. Pet dishes shall not be left on the floor or in reach of enrolled children.
E. Farm animals including horses, sheep, cattle, poultry, and fowl shall be kept in an enclosed area which is not accessible to enrolled children.

Historical Note
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TITLE 9. HEALTH SERVICES

CHAPTER 6. DEPARTMENT OF HEALTH SERVICES COMMUNICABLE DISEASES

ARTICLE 1. DEFINITIONS

Section
R9-6-101. General
R9-6-102. Communicable Disease Control
R9-6-103. Control Measures for Communicable Diseases
R9-6-104. Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS)
R9-6-105. Rabies Control
R9-6-106. Tuberculosis Control
R9-6-107. Vaccine Preventable Diseases
R9-6-108. Renumbered
R9-6-109. Reserved
R9-6-110. Reserved
R9-6-111. Repealed
R9-6-112. Renumbered
R9-6-113. Repealed
R9-6-114. Repealed

ARTICLE 2. COMMUNICABLE DISEASE REPORTING

Article 2, consisting of Section R9-6-201 and R9-6-202, renumbered from Article 6, Sections R9-6-601 and R9-6-602 effective October 19, 1993 (Supp. 93-4).

Article 2, consisting of Sections R9-6-201 through R9-6-203, renumbered to Article 5, Sections R9-6-501 through R9-6-503 effective October 19, 1993 (Supp. 93-4).

Section
R9-6-201. Responsibilities for Reporting
R9-6-202. Special Reporting Requirements
R9-6-203. Communicable Disease Reports
R9-6-204. Other Local Health Agency Control Measures
R9-6-205. Reserved
R9-6-206. Reserved
R9-6-207. Reserved
R9-6-208. Reserved
R9-6-209. Reserved
R9-6-210. Reserved
R9-6-211. Renumbered
R9-6-212. Renumbered
R9-6-213. Renumbered
R9-6-214. Renumbered

ARTICLE 3. CONTROL MEASURES FOR COMMUNICABLE AND PREVENTABLE DISEASES

Article 3, consisting of Sections R9-6-302 through R9-6-307, R9-6-309 through R9-6-311, R9-6-313, R9-6-315 through R9-6-317, R9-6-319 through R9-6-325, R9-6-327, R9-6-328, R9-6-330 through R9-6-356, and R9-6-358 through R9-6-366, renumbered from Article 7, Sections R9-6-701 through R9-6-746 and R9-6-748 through R9-6-759 effective October 19, 1993 (Supp. 93-4).

Article 3, consisting of Section R9-6-311, repealed (Supp. 91-2).

Section
R9-6-301. Diseases and Conditions Declared Reportable
R9-6-302. Amebiasis
R9-6-303. Anthrax
R9-6-304. Aseptic Meningitis: Viral
R9-6-305. Botulism
R9-6-306. Brucellosis
R9-6-307. Campylobacteriosis
R9-6-308. Chancroid (*Haemophilus ducreyi*)
R9-6-309. Chlamydia
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R9-6-311. Coccidioidomycosis (Valley Fever)
R9-6-312. Colorado Tick Fever
R9-6-313. Conjunctivitis: Acute
R9-6-314. Cryptosporidiosis
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R9-6-320. *Escherichia coli* O157:H7 Infection
R9-6-321. Foodborne/Waterborne Illness: Unspecified Agent
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R9-6-325. Hantavirus Infection
R9-6-326. Hepatitis A
R9-6-327. Hepatitis B and Delta Hepatitis
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R9-6-329. Hepatitis Non-A, Non-B
R9-6-330. Herpes Genitalis
R9-6-331. Human Immunodeficiency Virus (HIV) Infection and Related Disease
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R9-6-333. Legionellosis (Legionnaires' Disease)
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R9-6-359. Streptococcal Group B: Invasive Disease in Infants Less Than 30 Days of Age
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R9-6-367. Typhoid Fever
R9-6-368. Typhus Fever: Flea-borne
R9-6-369. Vancomycin Resistant *Entercoccus* spp.
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R9-6-372. Varicella (Chickenpox)
R9-6-373. Vibrio Infection
R9-6-374. Yellow fever
R9-6-375. Yersiniosis

ARTICLE 4. HUMAN IMMUNODEFICIENCY VIRUS (HIV) / ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

Article 4, consisting of Sections R9-6-401 through R9-6-408, renumbered from Article 8, Sections R9-6-801 through R9-6-808 effective October 19, 1993 (Supp. 93-4).

Article 4, consisting of Sections R9-6-411 through R9-6-419 and R9-6-431 through R9-6-433, repealed effective October 19, 1993 (Supp. 93-4).

Section
R9-6-401. Limitations and Termination of Program
R9-6-402. Eligibility
R9-6-403. Application Process
R9-6-404. Eligibility Determination and Enrollment Process
R9-6-405. Period of Eligibility
R9-6-406. Distribution Requirements
R9-6-407. Appeal
R9-6-408. Confidentiality
R9-6-409. Consent for HIV-related Testing
Exhibit A. Consent for HIV Testing
Exhibit B. Consentimiento Para la Prueba de VIH
R9-6-410. Human Immunodeficiency Virus Testing
R9-6-411. Repealed
R9-6-412. Repealed
R9-6-413. Repealed
R9-6-414. Repealed
R9-6-415. Repealed
R9-6-416. Repealed
R9-6-417. Repealed
R9-6-418. Repealed
R9-6-419. Repealed
R9-6-420. Reserved
R9-6-421. Reserved
R9-6-422. Reserved
R9-6-423. Reserved
R9-6-424. Reserved
R9-6-425. Reserved
R9-6-426. Reserved
R9-6-427. Reserved
R9-6-428. Reserved
R9-6-429. Reserved
R9-6-430. Reserved
R9-6-431. Repealed
R9-6-432. Repealed
R9-6-433. Repealed

ARTICLE 5. RABIES CONTROL

Article 5, consisting of Sections R9-6-501 through R9-6-503, renumbered from Article 2, Sections R9-6-201 through R9-6-203 effective October 19, 1993 (Supp. 93-4).

Article 5, consisting of Sections R9-6-501 through R9-6-506 and Tables 1 and 2, renumbered to Article 7, Sections R9-6-701 through R9-6-706 and Tables 1 and 2 effective October 19, 1993 (Supp. 93-4).

Article 5, consisting of Sections R9-6-501 through R9-6-506 and Tables 1 and 2, adopted effective January 20, 1992 (Supp. 92-1).

Article 5, consisting of Sections R9-6-501 through R9-6-504, repealed effective January 20, 1992 (Supp. 92-1).

Section
R9-6-501. Animals Exposed to a Known Rabid Animal
R9-6-502. Suspect Rabies Cases
R9-6-503. Records Submitted by Enforcement Agents
R9-6-504. Renumbered
R9-6-505. Renumbered
R9-6-506. Renumbered
Table 1. Renumbered
Table 2. Renumbered

ARTICLE 6. TUBERCULOSIS CONTROL

Article 6, consisting of Sections R9-6-601 through R9-6-603, adopted effective October 19, 1993 (Supp. 93-4).

Article 6, Sections R9-6-601 and R9-6-602, renumbered to Article 2, Sections R9-6-201 and R9-6-202, and Article 6, Sections R9-6-602 through R9-6-605 repealed effective October 19, 1993 (Supp. 93-4).

Section
R9-6-601. Reports of Disease and Infection; Tuberculosis Registry
R9-6-602. Issuance and Enforcement of an Order for Isolation and Quarantine
R9-6-603. Removal of Persons to Another State or Country
R9-6-604. Repealed
R9-6-605. Repealed
R9-6-606. Emergency Expired

ARTICLE 7. VACCINE PREVENTABLE DISEASES

Article 7, consisting of Sections R9-6-701 through R9-6-706, renumbered from Article 5 effective October 19, 1993 (Supp. 93-4).

Article 7 renumbered to Article 3 effective October 19, 1993 (Please refer to the individual Sections for the appropriate actions and new locations) (Supp. 93-4).

Section
R9-6-701. Required Immunizations for Child Care or School Entry
R9-6-702. Responsibilities of Physicians and Local Health Agencies for Administering Immunizations
R9-6-703. Standards for Documentary Proof
R9-6-704. Responsibilities of Schools
R9-6-705. Exemptions to Immunizations
R9-6-706. Required Reports
Table 1. Immunization Requirements for Child Care or School Entry
Table 2. Catch-Up Immunization Schedule for Child Care or School Entry
R9-6-707. Release of Immunization Information
Table 1. Immunization Requirements for Child Care and School Enrollment
Table 2. Recommended Schedule for Pupils Starting Immunization after School
R9-6-708. Renumbered
R9-6-709. Renumbered
R9-6-710. Renumbered
R9-6-711. Renumbered
R9-6-712. Renumbered
R9-6-713. Renumbered
R9-6-714. Renumbered
R9-6-715. Renumbered
R9-6-716. Renumbered

R9-6-717. Renumbered
R9-6-718. Renumbered
R9-6-719. Renumbered
R9-6-720. Renumbered
R9-6-721. Renumbered
R9-6-722. Renumbered
R9-6-723. Renumbered
R9-6-724. Renumbered
R9-6-725. Renumbered
R9-6-726. Renumbered
R9-6-727. Renumbered
R9-6-728. Renumbered
R9-6-729. Renumbered
R9-6-730. Renumbered
R9-6-731. Renumbered
R9-6-732. Renumbered
R9-6-733. Renumbered
R9-6-734. Renumbered
R9-6-735. Renumbered
R9-6-736. Renumbered
R9-6-737. Renumbered
R9-6-738. Renumbered
R9-6-739. Renumbered
R9-6-740. Renumbered
R9-6-741. Renumbered
R9-6-742. Renumbered
R9-6-743. Renumbered
R9-6-744. Renumbered
R9-6-745. Renumbered
R9-6-746. Renumbered
R9-6-747. Repealed
R9-6-748. Renumbered
R9-6-749. Renumbered
R9-6-750. Renumbered
R9-6-751. Renumbered
R9-6-752. Renumbered
R9-6-753. Renumbered
R9-6-754. Renumbered
R9-6-755. Renumbered
R9-6-756. Renumbered
R9-6-757. Renumbered
R9-6-758. Renumbered
R9-6-759. Renumbered

ARTICLE 8. RENUMBERED

Article 8, consisting of Sections R9-6-801 through R9-6-808, renumbered to Article 4, Sections R9-6-401 through R9-6-408 (Supp. 93-4).

Article 8 consisting of Sections R9-6-801 through R9-6-808 adopted as permanent rules effective May 22, 1989.

Article 8 consisting of Sections R9-6-801 through R9-6-808 readopted as an emergency effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days. Emergency expired.

Article 8 consisting of Sections R9-6-801 through R9-6-808 readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days. Emergency expired.

Article 8 consisting of Sections R9-6-801 through R9-6-809 readopted as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days.

Article 8 consisting of Sections R9-6-801 through R9-6-809 adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days. Emergency expired.

Section
R9-6-801. Renumbered
R9-6-802. Renumbered
R9-6-803. Renumbered
R9-6-804. Renumbered
R9-6-805. Renumbered
R9-6-806. Renumbered
R9-6-807. Renumbered
R9-6-808. Renumbered

ARTICLE 1. DEFINITIONS

R9-6-101. General

In this Chapter, unless the context otherwise requires:

1. "Approved" means acceptable to the Department.
2. "Authorized Representative" means a person designated by a physician, health care institution administrator, school, preschool, child care center, laboratory, or director of local health agency to perform specific tasks for the prevention, investigation, or reporting of a disease.
3. "Carrier" means an infected person who harbors an infectious agent in the absence of clinical disease and who serves as a potential source of infection.
4. "Case" means a person with a clinical syndrome of a communicable disease whose condition is documented by laboratory results which support the presence of the causative agent, or by a physician's diagnosis based on clinical observation, or by epidemiologic associations with communicable disease, the causative agent, or its toxic products.
5. "Communicable disease" means an illness caused by an infectious agent or its toxic products which arises through the transmission of that agent or its products to a susceptible host, either directly or indirectly.
6. "Communicable period" means the time during which an infectious agent may be transferred directly or indirectly from an infected person to another person; from an infected animal, arthropod, or vehicle to a person; or from an infected person to an animal.
7. "Employee" means any paid or volunteer, full or part-time worker at any facility or establishment.
8. "Epidemiologic investigation" means the application of scientific methods to verify the diagnosis, identify risk factors for the disease, determine the potential for spread, institute appropriate control measures and complete requisite communicable disease and case investigation reports.
9. "Food handler" means any employee of a food service establishment who prepares or serves food or who has direct contact with food.
10. "Foodborne/waterborne" means food or water serves as a source for the spread of disease or illness.
11. "HBsAG" means the hepatitis B surface antigen, the outer surface portion of the Hepatitis B Virus which can be detected in the blood of an individual with an active hepatitis B infection or a carrier of hepatitis B.
12. "Isolation" means the separation, during the communicable period, of infected persons or animals from others, so as to limit the transmission of infectious agents.
13. "Local health agency" means a county public health department, tribal health unit, or a United States Public Health Service Indian Health Service Unit.
14. "Outbreak" means an unexpected increase in incidence of a disease.
15. "Quarantine" means the restriction of activities of persons or animals who have been exposed to a case or carrier of a communicable disease during its communicable period.

16. "Syndrome" means a pattern of signs and symptoms characteristic of a specific disease.
17. "Special ventilation" means an air exhaust system which generates negative air pressure within a room and does not recirculate air exiting the room.
18. "Suspect carrier" means a person without clinical symptoms of disease but who tests positive for HIV by culture, antigen, antibodies to the virus, or viral genetic sequence detection.
19. "Suspect case" means a person whose medical history, signs, or symptoms indicate that person may have or is developing a communicable disease.

Historical Note
Adopted effective January 28, 1987 (Supp. 87-1).
Amended effective September 14, 1990 (Supp. 90-3).
Amended effective October 19, 1993 (Supp. 93-4).

R9-6-102. Communicable Disease Reporting
In Article 2, unless the context otherwise requires:
1. "Health care facility" means any hospital, medical clinic, or nursing care facility, whether organized for profit or not.
2. "Health care provider" means any physician, nurse, aide, therapist, dentist, or dental hygienist, whether paid or a volunteer.
3. "Medical information" means case, suspect case, carrier and suspect carrier reports; contact and suspect contact reports; and diagnostic information which is reported to the Department or a local health agency.

Historical Note
Adopted effective May 2, 1991 (Supp. 91-2). Former Section R9-6-102 renumbered to R9-6-105, new Section R9-6-102 renumbered from R9-6-106 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-103. Control Measures for Communicable Diseases
In Article 3, unless the context otherwise requires:
1. "Airborne precautions" means, in addition to Standard precautions, the use of respiratory protection by susceptible individuals and placement of the case in a negative pressure room.
2. "Barrier" means masks, gowns, gloves, face shields, face masks, or other membranes or filters to prevent the transmission of infectious agents and protect individuals from exposure to blood and body fluids.
3. "Body fluid" means semen, vaginal secretion, tissue, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid, urine, blood, or saliva.
4. "Concurrent disinfection" means the application of disinfective measures to inanimate objects or surfaces after the discharge of blood or body fluids from the body of an infected person, or after the contamination of articles with blood or body fluids.
5. "Contact precautions" means, in addition to Standard precautions, the use of barriers to prevent infection spread by direct contact.
6. "Contaminated" means to have come in contact with a disease-causing agent or toxin.
7. "Counseling and testing site" means a health facility offering clients HIV counseling and testing which meets the standards established in the "HIV Counseling, Testing, and Referral, Standards and Guidelines," May 1994, Centers for Disease Control, 1600 Clifton Road, N.E., Atlanta, GA 30333, incorporated by reference and on file with the Department and Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
8. "Disinfection" means killing or inactivating communicable disease causing agents on inanimate objects by directly applied chemical or physical means.
9. "Disinfestation" means any physical, biological, or chemical process to reduce or eliminate undesired arthropod or rodent populations.
10. "Droplet precautions" means, in addition to Standard precautions, the use of a mask when working within 3 feet of the case.
11. "Follow-up" means the practice of investigating and monitoring cases, carriers, contacts or suspect cases, to detect, treat or prevent disease.
12. "Standard precautions" means the use of barriers to prevent contact with blood, mucous membranes, nonintact skin, all body fluids, and secretions (except sweat).

Historical Note
Renumbered from R9-6-107 and amended effective October 19, 1993 (Supp. 93-4). Amended effective April 4, 1997 (Supp. 97-2).

R9-6-104. Human Immunodeficiency Virus (HIV)/ Acquired Immunodeficiency syndrome (AIDS)
In Article 4, unless the context otherwise requires:
1. "AHCCCS" means the Arizona Health Care Cost Containment System.
2. "Clinical trial study" means the Treatment IND (investigative new drug) trial of zidovudine conducted by Burroughs-Wellcome Company between October 11, 1986, and April 30, 1987.
3. "Enrolled" means eligible for and being provided therapeutic assistance by the Department.
4. "Family" means a group of two or more persons related by birth, marriage, or adoption who reside together; all such related persons are considered members of one family. If a household includes more than one family and/or more than one unrelated individual, the poverty guidelines are applied separately to each family and/or unrelated individual, and not to the household as a whole.
5. "Family unit of size one" means an unrelated individual, that is, a person 15 years old or older (other than an inmate of an institution) who is not living with relatives. An unrelated individual may be the sole occupant of a housing unit, or may be residing in a housing unit, including a rooming house, in which one or more persons also reside who are not related to the individual in question by birth, marriage, or adoption.
6. "Income" means the total annual cash receipts before taxes from all sources; it may consist of data for the most recent 12 months or an annualized figure derived by computation from less than 12 months' data. Income includes money, wages and salaries before any deductions, but does not include food or rent received in lieu of wages. Income also includes net receipts from nonfarm or farm self-employment, net of business or farm expenses. Income includes regular payments from social security, railroad retirement, unemployment compensation, workers' compensation, strike benefits from union funds, veterans' benefits, public assistance (including Aid to Families with Dependent Children, Supplemental Security Income, and non-Federally-funded General Assistance or General Relief money payments), training stipends, alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household, private

and government employee pensions, and regular insurance or annuity payments, and income from dividends, interest, rents, royalties, or periodic receipts from estates or trusts. For eligibility purposes, income does not include: capital gains, any assets drawn down as withdrawals from a bank, proceeds from the sale of property, a house, or a car; tax refunds, gifts, lump-sum inheritances, one-time insurance payments, or compensation for injury. Also excluded are noncash benefits, such as the employer-paid or union-paid portion of health insurance and other employee fringe benefits; the value of food and fuel produced and consumed on farms, the imputed value of rent from owner-occupied nonfarm or farm housing, and federal programs such as Medicare, Medicaid, food stamps, school lunches, and public housing.

7. "SSI" means Supplemental Security Income, a program of the Social Security Administration.
8. "Symptomatic HIV infection" means illness either within the case definition of the Centers for Disease Control for acquired immunodeficiency syndrome (AIDS) or generally recognized as AIDS related complex (ARC). Incorporated by reference herein and on file with the Office of the Secretary of State is Morbidity and Mortality Weekly Report: Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome, Centers for Disease Control, Atlanta, Georgia, Vol. 36, No. 15, August 14, 1987.
9. "Therapeutic agents" means drugs determined by the United States Food and Drug Administration to prolong the life of individuals with symptomatic HIV infection.
10. "Zidovudine" means azidothymidine (AZT).

Historical Note
Renumbered from R9-6-108 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-105. Rabies Control
In Article 5, unless otherwise specified:

1. "Animal control agency" means a governmental agency or its designated representative with local responsibility for controlling dogs and cats.
2. "Cat" means an animal of the genus species *Felis domesticus*.
3. "Dog" means an animal of the genus species *Canis familiaris*.
4. "Euthanize" means to put an animal to death painlessly.
5. "Exposed" means bitten by or having direct contact with a rabies susceptible animal.

Historical Note
Adopted effective January 20, 1992 (Supp. 92-1). Former Section R9-6-105 renumbered to R9-6-107, new Section R9-6-105 renumbered from R9-6-102 and amended effective October 19, 1993 (Supp. 93-4). Amended effective April 4, 1997 (Supp. 97-2).

R9-6-106. Tuberculosis Control
In Article 6, unless the context otherwise requires:

1. "Approved institution" means a health care facility with a current license to operate pursuant to A.A.C. Title 9, Chapter 10, which has a private room with special ventilation.
2. "State Tuberculosis Control Officer" means a physician, appointed by the Director, with the authority to issue or revoke an Order of Isolation and Quarantine and to deputize a qualified employee of the Department and other governmental agency as a Deputy Tuberculosis Control Officer.
3. "Tuberculosis infection" means the bacteria in *Mycobacteria tuberculosis* complex has spread through the body of a person but is not contagious.
4. "Tuberculosis disease" means the bacteria in *Mycobacteria tuberculosis* complex is causing clinical signs and symptoms and is contagious, unless the bacteria cannot exit the body.

Historical Note
Amended effective June 4, 1980 (Supp. 80-3). Former Section R9-6-112 renumbered and amended as Section R9-6-106 effective January 28, 1987 (Supp. 87-1). Former Section R9-6-106 renumbered to R9-6-102, new Section R9-6-106 adopted effective October 19, 1993 (Supp. 93-4).

R9-6-107. Vaccine Preventable Diseases
In Article 7, unless otherwise specified:

1. "ASIIS" means the Arizona State Immunization Information System, an immunization reporting system that collects, stores, analyzes, releases, and reports immunization data.
2. "Catch-up immunization schedule" means set times in Table 2 for immunizations for a child, an individual more than 18 years of age, or an emancipated person who has not completed the vaccine series required in Table 1 before child care or school entry.
3. "Child" means an individual 18 years of age or less.
4. "Child care" means:
   a. A child care facility as defined in A.R.S. § 36-881;
   b. A child care home as defined in A.R.S. § 46-807;
   c. A child care group home as defined in A.R.S. § 36-897;
   d. A child care home receiving monies under A.R.S. § 46-321; or
   e. A Head Start program operating under the Head Start Act, 42 U.S.C. 9801, et seq.
5. "DT" means diphtheria and tetanus vaccine for a child less than 7 years of age.
6. "DTaP" means diphtheria, tetanus, and acellular pertussis vaccine.
7. "DTP" means diphtheria, tetanus, and pertussis vaccine.
8. "Emancipated person" means the same as the definition in A.R.S. § 15-1801.
9. "Entry" means 1st day of attendance at a child care or at a specific grade level in a school.
10. "Guardian" means an individual appointed by a court of competent jurisdiction to care for the person or property of a child.
11. "Hep A" means hepatitis A vaccine.
12. "Hep B" means hepatitis B vaccine.
13. "Hib" means *Haemophilus influenzae* type b vaccine.
14. "IPV" means inactivated polio vaccine.
15. "Kindergarten" means the grade level in a school that precedes 1st grade.
16. "MMR" means measles, mumps, and rubella vaccine.
17. "OPV" means oral polio vaccine.
18. "Parochial" means supported by a church or religious order.
19. "*Person in loco parentis*" means an individual acting in the place of a parent or guardian and exercising parental duties, rights or responsibilities.
20. "Responsible person" means:
   a. A parent, guardian, or *person in loco parentis* of a child;
   b. An individual more than 18 years of age; or
   c. An emancipated person.

21. "School" means the same as the definition in A.R.S. § 36-671.
22. "Td" means tetanus and diphtheria vaccine, for an individual aged 7 years and older.
23. "Vaccine" means any immunizing agent approved and licensed by the U.S. Department of Health and Human Services, Public Health Service, Food and Drug Administration, for the prevention and control of vaccine preventable diseases as set forth in "Establishments and Products Licensed Under Section 351 of the Public Health Service Act," HHS Publication No. (FDA)-89-9003, September 30, 1989, pp. 111-150, Center for Biologics Evaluation and Research, 8800 Rockville Pike, Bethesda, Maryland 20892, incorporated by reference, and on file with the Department and the Office of the Secretary of State. This incorporation by reference includes no future editions or amendments.

Historical Note
Adopted effective September 14, 1990 (Supp. 90-3). Former Section R9-6-107 renumbered to R9-6-103, new Section R9-6-107 renumbered from R9-6-105 and amended effective October 19, 1993 (Supp. 93-4). Amended effective April 4, 1997 (Supp. 97-2). Amended by final rulemaking at 5 A.A.R. 496, effective January 19, 1999 (Supp. 99-1).

R9-6-108. Renumbered

Historical Note
Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Amended and readopted as an emergency effective August 8. 1988 pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted as an emergency and Paragraph (9) corrected effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Adopted without change as a permanent rule effective May 22, 1989 (Supp. 89-2). Renumbered to R9-6-104 effective October 19, 1993 (Supp. 93-4).

R9-6-109. Reserved

R9-6-110. Reserved

R9-6-111. Repealed

Historical Note
Corrected Departmental reference in subsection (C) (Supp. 76-5). Amended effective June 4, 1980 (Supp. 80-3. Repealed effective January 28, 1987 (Supp. 87-1).

R9-6-112. Renumbered

Historical Note
Amended effective June 4, 1980 (Supp. 80-3). Former Section R9-6-112 renumbered and amended as Section R9-6-106 effective January 28, 1987 (Supp. 87-1).

R9-6-113. Repealed

Historical Note
Former Section R9-6-113 repealed, new Section R9-6-113 adopted effective June 4, 1980 (Supp. 80-3). Amended paragraph 4, effective January 31, 1983 (Supp. 83-1). Repealed effective January 28, 1987 (Supp. 87-1).

R9-6-114. Repealed

Historical Note
Corrected Departmental reference in subsections (B) and (C) (Supp. 76-5). Former Section R9-6-114 repealed, new Section R9-6-114 adopted effective June 4, 1980 (Supp. 80-3). Repealed effective January 28, 1987 (Supp. 87-1).

ARTICLE 2. COMMUNICABLE DISEASE REPORTING

R9-6-201. Responsibilities for Reporting
Within five business days of diagnosis or treatment, a physician or an administrator of a health care facility or an authorized representative shall submit a communicable disease report to the local health agency unless otherwise specified in this Chapter.

Historical Note
Former Section R9-6-211 renumbered and amended and subsection (C) renumbered from R9-6-212 and amended effective May 2, 1991 (Supp. 91-2). Former Section R9-6-201 renumbered to R9-6-501, new Section R9-6-201 renumbered from R9-6-601, repealed, and a new Section R9-6-201 adopted effective October 19, 1993 (Supp. 93-4).

R9-6-202. Special Reporting Requirements

A. A physician or an administrator of a health care facility, or an authorized representative, shall submit a communicable disease report of a case or a suspect case of the following diseases and conditions within 24 hours of diagnosis to the local health agency by telephone or other equally expeditious means:
1. Botulism,
2. Cholera,
3. Diphtheria,
4. *Haemophilus influenzae* type b: invasive disease,
5. Measles (rubeola),
6. Meningococcal invasive disease,
7. Outbreaks of foodborne/waterborne illness,
8. Pertussis (whooping cough),
9. Plague,
10. Poliomyelitis,
11. Rabies in humans,
12. Rubella (German measles),
13. Tuberculosis diseases; including tuberculosis infection in a child less than 6 years of age,
14. Vancomycin resistant *Staphylococcus aureus*, and
15. Yellow fever.

B. A physician or an administrator of a health care facility, or an authorized representative, shall submit a communicable disease report of a case, suspect case or carrier of the following diseases in a food handler, nursing home caregiver or child care worker within 24 hours of diagnosis to the local health agency by telephone or other equally expeditious means:
1. Amebiasis,
2. Campylobacteriosis,
3. *Escherichia coli* O157:H7 infection,
4. Giardiasis,
5. Hepatitis A or unspecified,
6. Salmonellosis,
7. Shigellosis, and
8. Typhoid fever.

C. An administrator or authorized representative of a school, child care center or preschool shall report by telephone or equally expeditious means within 24 hours of discovery to the local health agency, an outbreak of:
1. Foodborne/waterborne illness,
2. Giardiasis,
3. *Haemophilus influenzae* type b: invasive disease,

4. Hepatitis A,
5. Measles (rubeola),
6. Meningococcal invasive disease,
7. Mumps,
8. Pertussis (whooping cough),
9. Rubella (German measles),
10. Scabies, and
11. Shigellosis.

D. A clinical laboratory director, or authorized representative, shall submit to the Department a weekly written, or electronic report of positive laboratory findings for the following communicable disease pathogens:

1. *Bordetella pertussis*;
2. *Brucella* sp.;
3. *Campylobacter sp.*;
4. *Chlamydia trachomatis*;
5. *Coccidioides immitis*: culture or serologies;
6. *Cryptosporidium* sp.;
7. *Escherichia coli* O157:H7;
8. Group A *Streptococcus*: isolated from normally sterile site, tissue, or body fluid;
9. Group B *Streptococcus*: isolated from normally sterile site, tissue or body fluid;
10. *Haemophilus influenzae*: isolated from normally sterile sites;
11. Hantavirus;
12. Hepatitis A Virus (anti HAV-IgM serologies);
13. Hepatitis B Virus (anti-Hepatitis B core-IgM serologies and Hepatitis B surface antigen serologies);
14. Hepatitis C Virus (anti-Hepatitis C RIBA, PCR or other confirmatory test);
15. Hepatitis Delta Virus;
16. Human Immunodeficiency Virus (HIV);
17. Human T-cell Lymphotropic Virus type I and II;
18. *Legionella* sp.: culture or DFA;
19. *Listeriosis* sp.: culture isolated from normally sterile sites only;
20. *Mycobacterium tuberculosis* and its drug sensitivity pattern;
21. *Neisseria gonorrhoeae;*
22. *Neisseria meningitidis*;
23. *Plasmodium* sp.;
24. *Streptococcus pneumoniae* and its drug sensitivity pattern: culture isolated from normally sterile sites only;
25. *Treponema pallidum* (syphilis);
26. Vancomycin resistant *Entercoccus;*
27. Vancomycin resistant *Staphylococcus aureus*;
28. Vancomycin resistant *Staphylococcus epidermidis*;
29. *Vibrio* sp.; and
30. *Yersinia* sp.

E. The written or electronic laboratory report shall include:

1. Name, and if available, address, and telephone number of the patient;
2. Birth date of the patient;
3. Reference number;
4. Specimen type;
5. Date of collection;
6. Type of test;
7. Test results; and
8. Ordering physician's name and telephone number.

F. A clinical laboratory director, or authorized representative, shall submit isolates of the following organisms to the Arizona State Laboratory:

1. *Bordetella pertussis*,
2. *Haemophilus influenzae* from sterile sites only,
3. Group A *Streptococcus* from sterile sites only,
4. *Neisseria meningitidis*,
5. *Salmonella* sp., and
6. Vancomycin resistant *Staphylococcus aureus*.

Historical Note

Renumbered from R9-6-213 and amended effective May 2, 1991 (Supp. 91-2). Former Section R9-6-202 renumbered to R9-6-502, new Section R9-6-202 renumbered from R9-6-602 and amended effective October 19, 1993 (Supp. 93-4). Amended effective April 4, 1997 (Supp. 97-2).

R9-6-203. Communicable Disease Reports

A. The Department shall supply forms which shall be used for written reports of suspected or confirmed disease. The forms shall include:

1. Patient's name, address, telephone number, date of birth, race or ethnicity, gender, and occupation;
2. Disease, date of onset, date of diagnosis, date of laboratory confirmation, and test results; and
3. Name, address, and telephone number of the person or agency making the report.

B. The local health agency shall forward the original copy of the reports to the Department each week, specifying what action, if any, was initiated. The local health agency shall forward to the Department reports of disease in a nonresident of that jurisdiction who is or has been treated in that jurisdiction.

C. Within 30 days of the completion of any outbreak investigation conducted pursuant to this Article, the local health agency shall submit to the Department a written summary of the outbreak investigation to include: a description of the location, the time of notification of the outbreak, how the outbreak was verified, the number of persons reported to be ill, the number of persons estimated at risk for illness, the definition of a case, laboratory evidence collected and results, hypotheses as to how the outbreak occurred, control measures that were implemented, conclusions based upon the results of the investigation, and the recommendations to prevent future occurrences.

Historical Note

Renumbered from R9-6-214 and amended effective May 2, 1991 (Supp. 91-2). Former Section R9-6-203 renumbered to R9-6-503, new Section R9-6-202 adopted effective October 19, 1993 (Supp. 93-4).

R9-6-204. Other Local Health Agency Control Measures

The local health agency shall review communicable disease reports for completeness and accuracy, confirm diagnoses, conduct investigations, facilitate notification of known contacts, conduct surveillance, determine trends, and implement quarantines, isolations, and exclusions.

Historical Note

Adopted effective October 19, 1993 (Supp. 93-4).

R9-6-205. Reserved

R9-6-206. Reserved

R9-6-207. Reserved

R9-6-208. Reserved

R9-6-209. Reserved

R9-6-210. Reserved

R9-6-211. Renumbered

Historical Note

Renumbered to R9-6-201 effective May 2, 1991 (Supp. 91-2).

R9-6-212. Renumbered

Historical Note
Renumbered to R9-6-201(C) effective May 2, 1991 (Supp. 91-2).

R9-6-213. Renumbered

Historical Note
Renumbered to R9-6-202 effective May 2, 1991 (Supp. 91-2).

R9-6-214. Renumbered

Historical Note
Renumbered to R9-6-203 effective May 2, 1991 (Supp. 91-2).

ARTICLE 3. CONTROL MEASURES FOR COMMUNICABLE AND PREVENTABLE DISEASES

R9-6-301. Diseases and Conditions Declared Reportable
The following diseases listed below are reportable. The diseases and corresponding Sections of this Article which designate the case control, contact control, environmental control, special control and outbreak control measures, if any for each such reportable disease, are listed below:

R9-6-302.	Amebiasis
R9-6-303.	Anthrax
R9-6-304.	Aseptic meningitis: viral
R9-6-305.	Botulism
R9-6-306.	Brucellosis
R9-6-307.	Campylobacteriosis
R9-6-308.	Chancroid (*Haemophilus ducreyi*)
R9-6-309.	Chlamydia
R9-6-310.	Cholera
R9-6-311.	Coccidioidomycosis (valley fever)
R9-6-312.	Colorado tick fever
R9-6-313.	Conjunctivitis: acute
R9-6-314.	Cryptosporidosis
R9-6-315.	Dengue
R9-6-317.	Diphtheria
R9-6-318.	Ehrlichiosis
R9-6-319.	Encephalitis: viral
R9-6-320.	*Escherichia coli* O57: H7 infection
R9-6-321.	Foodborne/Waterborne illness: unspecified agent
R9-6-322.	Giardiasis
R9-6-323.	Gonorrhea
R9-6-324.	*Haemophilus influenzae*: Invasive Disease
R9-6-325.	Hantavirus Infection
R9-6-326.	Hepatitis A
R9-6-327.	Hepatitis B and delta virus
R9-6-328.	Hepatitis C
R9-6-329.	Hepatitis Non-A, Non-B
R9-6-330.	Herpes genitalis
R9-6-331.	Human Immunodeficiency Virus (HIV) infection and related disease
R9-6-332.	Human T-cell Lymphotropic Virus (HTLV-I/II) type I and II infection
R9-6-333.	Legionellosis (Legionnaires' disease)
R9-6-334.	Leprosy
R9-6-335.	Leptospirosis
R9-6-336.	Listeriosis
R9-6-337.	Lyme disease
R9-6-338.	Malaria
R9-6-339.	Measles (rubeola)
R9-6-340.	Meningococcal invasive disease
R9-6-341.	Mumps
R9-6-343.	Pertussis (whooping cough)
R9-6-344.	Plague
R9-6-345.	Poliomyelitis
R9-6-346.	Psittacosis
R9-6-347.	Q fever
R9-6-348.	Rabies in humans
R9-6-349.	Relapsing fever (borreliosis)
R9-6-350.	Reye syndrome
R79-6-351.	Rocky Mountain spotted fever
R9-6-352.	Rubella (German measles)
R9-6-353.	Rubella syndrome, congenital
R9-6-354.	Salmonellosis
R9-6-355.	Scabies
R9-6-356.	Shigellosis
R9-6-358.	Streptococcal-Group A: Invasive Disease
R9-6-359.	Streptococcal Group B: Invasive Disease in Infants Less Than 30 Days of Age
R9-6-360.	Syphilis
R9-6-361.	Taeniasis
R9-6-362.	Tetanus
R9-6-363.	Toxic shock syndrome
R9-6-364.	Trichinosis
R9-6-365.	Tuberculosis
R9-6-366.	Tularemia
R9-6-367.	Typhoid fever
R9-6-368.	Typhus fever: flea-borne
R9-6-369.	Vancomycin resistant *Entercoccus* sp.
R9-6-370.	Vancomycin resistant *Staphylococcus aureus*
R9-6-371.	Vancomycin resistant *Staphylococcus epidermidis*
R9-6-372.	Varicella (chickenpox)
R9-6-373.	Vibrio infection
R9-6-374.	Yellow fever
R9-6-375.	Yersiniosis

Historical Note
Adopted effective October 19, 1993 (Supp. 93-4).
Amended effective April 4, 1997 (Supp. 97-2).

R9-6-302. Amebiasis

A. Case control measures: The local health agency shall exclude a case from food handling until treatment with an amebicide is completed and two successive negative fecal examinations are obtained from specimens collected 24 hours or more apart.

B. Contact control measures: The local health agency shall exclude contacts with symptoms of amebiasis from working as a food handler until two successive negative fecal examinations for the presence of amoeba are obtained from specimens collected 24 hours or more apart.

C. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case regarding handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, the health care provider shall counsel the person responsible for care.

D. Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak.

Historical Note
Renumbered from R9-6-702 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-303. Anthrax

A. Environmental control measures: The local health agency shall provide or arrange for incineration or sterilization by dry heating of contaminated products, products which have been in direct contact with contaminated products, and articles soiled with discharges from lesions.

B. Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note
Renumbered from R9-6-703 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-304. Aseptic Meningitis: Viral
Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak.

Historical Note
Renumbered from R9-6-704 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-305. Botulism
A. Environmental control measures: The person in possession shall discard contaminated food after boiling it for ten minutes. The person in possession shall boil contaminated utensils for ten minutes prior to reuse or disposal.
B. Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note
Renumbered from R9-6-705 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-306. Brucellosis
Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note
Renumbered from R9-6-706 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-307. Campylobacteriosis
A. Case control measures: The local health agency shall exclude a case from handling food until a negative stool culture is obtained or until treatment is maintained for 24 hours and symptoms of campylobacteriosis are absent.
B. Contact control measures: The local health agency shall exclude contacts with symptoms of campylobacteriosis from working as a food handler until a negative stool culture is obtained or symptoms are absent.
C. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, the health care provider shall counsel the person responsible for care.
D. Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak.

Historical Note
Former Section R9-6-115, Paragraph (5), renumbered and amended as R9-6-707 effective January 28, 1987 (Supp. 87-1).

R9-6-308. Chancroid (*Haemophilus ducreyi*)
A. Case control measures: The diagnosing health care provider or authorized representative shall treat and counsel a case to abstain from sexual contact until lesions are healed.
B. Contact control measures: The local health agency shall notify sexual contacts of exposure and offer or arrange for treatment.

Historical Note
Adopted effective October 19, 1993 (Supp. 93-4).

R9-6-309. Chlamydia
A. Reports: Suspect cases include clinically diagnosed cases of nongonococcal urethritis and epididymitis in men under age 35 years, and pelvic inflammatory disease and nongonococcal mucopurulent cervicitis in women.
B. Case control measures: The diagnosing health care provider or authorized representative shall counsel a case to abstain from sexual contact until treatment is complete.
C. Contact control measures: The local health agency shall notify identified sexual contacts and offer or arrange for treatment.
D. Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note
Renumbered from R9-6-708 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-310. Cholera
A. Case control measures: The local health agency shall exclude a case from handling food, caring for patients, working in or attending a child care center or preschool until 2 negative fecal examinations have been obtained from specimens collected 24 hours or more apart.
B. Contact control measures: The local health agency shall provide follow-up for 5 days after exposure. The local health agency shall exclude a contact with symptoms of cholera from handling food, caring for patients, working in or attending a child care center or preschool until 2 successive negative fecal examinations have been obtained from specimens collected 24 hours or more apart.
C. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.
D. Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note
Renumbered from R9-6-709 and amended effective October 19, 1993 (Supp. 93-4). Amended effective April 4, 1997 (Supp. 97-2).

R9-6-311. Coccidioidomycosis (Valley Fever)
Reports: The local health agency shall epidemiologically describe each reported outbreak.

Historical Note
Repealed effective May 2, 1991 (Supp. 91-2). New Section R9-6-311 renumbered from R9-6-710 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-312. Colorado Tick Fever
Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note
Adopted effective October 19, 1993 (Supp. 93-4).

R9-6-313. Conjunctivitis: Acute
A. Case control measures: An administrator or authorized representative of a public or private school, child care center, or preschool shall exclude a case until symptoms subside or treatment for acute conjunctivitis is initiated and maintained for 24 hours.
B. Special control measures: The diagnosing health care provider or authorized representative shall counsel a case about hand-

washing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, the health care provider shall counsel the person responsible for care.

Historical Note
Renumbered from R9-6-711 and amended effective October 19, 1993 (Supp. 93-4). Amended effective April 4, 1997 (Supp. 97-2).

R9-6-314. Cryptosporidiosis
Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, the health care provider shall counsel the person responsible for care.

Historical Note
Adopted effective October 19, 1993 (Supp. 93-4). Amended effective April 4, 1997 (Supp. 97-2).

R9-6-315. Dengue
Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note
Renumbered from R9-6-712 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-316. Diarrhea of Newborn
A. Case control measures: An administrator of a hospital or an authorized representative shall isolate or group cases or suspect cases in a separate area. A health care provider shall use enteric precautions for a hospitalized case.
B. Contact control measures. An administrator of a hospital, or an authorized representative, shall provide follow-up of newborn contacts for a period of two weeks following the date the last case is discharged from the nursery.
C. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel the person responsible for care.
D. Special control measures: An administrator of a hospital or an authorized representative shall not admit additional infants to the contaminated area until all exposed infants have been discharged and the nursery has been cleaned and disinfected.

Historical Note
Renumbered from R9-6-713 and amended effective October 19, 1993 (Supp. 93-4). Amended effective April 4, 1997 (Supp. 97-2).

R9-6-317. Diphtheria
A. Case control measures: The diagnosing health care provider shall isolate a hospitalized case until either of the following occurs:
1. Two successive negative cultures each from the nose and throat or skin are obtained from specimens collected 24 hours or more apart and 24 hours or more after cessation of treatment, or
2. Fourteen days after initiation of treatment.

B. Contact control measures: The local health agency shall:
1. Exclude contacts from handling food until a negative culture of the nose and throat or skin is obtained.
2. Quarantine household contacts until two successive negative cultures each from the nose and throat or skin have been obtained 24 hours or more apart.
3. Offer previously immunized contacts a vaccine containing diphtheria toxoid.
4. Offer unimmunized contacts the primary vaccine series and treatment.

C. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.
D. Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note
Renumbered from R9-6-714 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-318. Ehrlichiosis
Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note
Adopted effective October 19, 1993 (Supp. 93-4).

R9-6-319. Encephalitis: Viral
Special control measures: The local health agencies shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note
Renumbered from R9-6-715 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-320. *Escherichia coli* O157:H7 Infection
A. Case control measures: The local health agency shall exclude a case with symptoms of *Escherichia coli* O157:H7 from handling food or attending child care until either of the following occurs:
1. Two successive stool cultures obtained from specimens collected 24 hours or more apart are negative, or
2. Symptoms are absent.

B. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.
C. Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak.

Historical Note
Renumbered from R9-6-716 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-320 renumbered to Section R9-6-321; new Section R9-6-320 adopted effective April 4, 1997 (Supp. 97-2).

R9-6-321. Foodborne/Waterborne Illness: Unspecified Agent
A. Environmental control measures: The local health agency shall conduct or assure that a sanitary inspection is conducted of the water, sewage, or food preparation facilities associated with an outbreak of foodborne/waterborne illness.
B. Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak.

Historical Note
Renumbered from R9-6-717 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-321 renumbered to R9-6-322; new Section R9-6-321 renumbered from R9-6-320 effective April 4, 1997 (Supp. 97-2).

R9-6-322. Giardiasis

A. Case control measures: The local health agency shall exclude a case from handling food or attending a child care center or a preschool, until either of the following occurs:
1. Two negative fecal examinations have been obtained from specimens collected 24 hours or more apart, or
2. Treatment for giardiasis is initiated and the case no longer has symptoms.

B. Contact control measures: The local health agency shall exclude a contact with symptoms of giardiasis from handling food or attending child care centers or preschools until the contact no longer has symptoms.

C. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.

D. Outbreak control measures: The local health agency shall provide education and consultation regarding prevention and control measures to cases and known contacts.

Historical Note

Renumbered from R9-6-718 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-322 renumbered to R9-6-323; new Section R9-6-322 renumbered from R9-6-321 effective April 4, 1997 (Supp. 97-2).

R9-6-323. Gonorrhea

A. Case control measures: The diagnosing health care provider shall counsel the case to abstain from sexual contact for 7 days after treatment is completed.

B. Contact control measures: The local health agency shall assure identification and notification and shall offer treatment to sexual contacts.

C. Special control measures:
1. For the prevention of gonorrheal ophthalmia, the physician or person attending the birth of any newborn in Arizona shall treat the eyes of the baby immediately after the birth with 1 of the following medications:
   a. Erythromycin ophthalmic ointment 0.5%,
   b. Tetracycline ophthalmic ointment 1%,
   c. Silver nitrate aqueous solution 1%.
2. A parent or guardian may refuse the treatment set forth in subsection (C)(1) by signing a written statement, witnessed by the physician or person attending the birth, stating that the parent or guardian has been informed of the potential risks and benefits of waiving the prescribed treatment and is refusing to allow its application. The physician or person attending the birth shall maintain a copy of the written refusal in the newborn's medical record.
3. The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Renumbered from R9-6-719 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-323 renumbered to R9-6-324; new Section R9-6-323 renumbered from R9-6-322 and amended effective April 4, 1997 (Supp. 97-2).

R9-6-324. *Haemophilus Influenzae*: Invasive Diseases

A. Reports: A health care provider shall report invasive diseases including meningitis, epiglottitis, bacteremia, pneumonia, septic arthritis, and cellulitis.

B. Case control measures: The diagnosing health care provider shall isolate a hospitalized case for 24 hours following the initiation of treatment.

C. Contact control measures: The local health agency shall evaluate the risk of exposure to contacts and, if indicated, provide or arrange for immunization or treatment.

D. Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Renumbered from R9-6-720 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-324 renumbered to R9-6-326; new Section R9-6-324 renumbered from R9-6-323, effective April 4, 1997 (Supp. 97-2).

R9-6-325. Hantavirus Infection

Environmental control measures: A local health agency shall provide or arrange for the provision of education on reducing risks of hantavirus infection to the patient.

Historical Note

Renumbered from R9-6-721 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-325 renumbered to R9-6-327; new Section R9-6-325 adopted effective April 4, 1997 (Supp. 97-2).

R9-6-326. Hepatitis A

A. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.

B. Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak. The local health agency shall evaluate the risk of exposure and, if indicated, provide or arrange for prophylaxis.

C. Special control measures: The local health agency shall:
1. Exclude a case from handling food during the 1st 14 days of illness or for 7 days after the onset of jaundice.
2. Provide follow-up of food handlers who are household contacts with a case or who consumed food prepared by a case during the infectious period for 45 days following the exposure.

Historical Note

Adopted effective October 19, 1993 (Supp. 93-4). Former Section R9-6-326 renumbered to R9-6-329; new Section R9-6-326 renumbered from R9-6-324 and amended effective April 4, 1997 (Supp. 97-2).

R9-6-327. Hepatitis B and Delta Hepatitis

A. Case control measures: A health care provider or operator of a blood or plasma center shall not utilize donated blood, plasma, body organs, sperm, or other tissue from a case, suspect case, or carrier for transfusion or transplantation.

B. Contact control measures: The local health agency shall refer exposed non-immune persons to a physician for prophylaxis and initiation of the hepatitis B vaccine series.

C. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, the health care provider shall counsel the person responsible for care.

D. Special control measures:

1. Control of donors: A health care provider or operator of a blood or plasma center shall exclude:
   a. Anyone who has, or has had, hepatitis B or delta hepatitis or demonstrates serologic evidence of having the hepatitis B surface antigen (HBsAg) from donating blood, plasma, sperm, organ, or tissue.
   b. Anyone who has received a transfusion of blood or blood product from donating blood for 6 months following the transfusion.
2. Control of an infectious health care provider: The local health agency shall evaluate a health care provider who is identified as the source of Hepatitis B Virus transmission in the work place and, if indicated, shall ensure reassignment of the health care provider to a position where the occupational risk of transmission is eliminated.
3. The local health agency shall conduct or direct an epidemiological investigation of each reported case of hepatitis B or delta hepatitis.
4. Any person operating a blood or plasma center who interprets, as positive, a test for the hepatitis B surface antigen (HbsAg) or hepatitis B core IgM antibodies (HBcAb-IgM), in addition to meeting the reporting requirements specified in R9-6-202 shall, within 30 days of performing the test, notify the person on whom the test was performed.

Historical Note
Renumbered from R9-6-722 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-327 renumbered to R9-6-330; new Section R9-6-327 renumbered from R9-6-325 and amended effective April 4, 1997 (Supp. 97-2).

R9-6-328. Hepatitis C

A. Case control measures: A health care provider or operator of a blood or plasma center shall not utilize donated blood, plasma, body organs, sperm, or other tissue from a case, suspect case, or suspect carrier for transfusion or transplantation.

B. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the persons responsible for their care.

C. Special control measures: Any person operating a blood or plasma center who interprets, as positive, a test for HCV or antibodies to HCV, shall within 30 days of verifying the final results of the test, notify the person on whom the test was performed.

Historical Note
Renumbered from R9-6-701 and amended effective October 19, 1993 (Supp. 93-4). Former Section R6-6-328 renumbered to R9-6-331; new Section R9-6-328 adopted effective April 4, 1997 (Supp. 97-2).

R9-6-329. Hepatitis Non-A, Non-B

A. Case control measures: A health care provider or operator of a blood or plasma center shall not utilize donated blood, plasma, body organs, sperm, or other tissue from a case, suspect case, or carrier for transfusion or transplantation.

B. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, the health care provider shall counsel the person responsible for care.

C. Special control measures: Any person operating a blood or plasma center who interprets, as positive, a test for HCV or antibodies to HCV shall, within 30 days of verifying the final results of the test, notify the person on whom the test was performed.

Historical Note
Adopted effective October 19, 1993 (Supp. 93-4). Section R9-6-329 renumbered to R9-6-332; new Section R9-6-329 renumbered from R9-6-326 and amended effective April 4, 1997 (Supp. 97-2).

R9-6-330. Herpes Genitalis

Case control measures: The diagnosing health care provider or authorized representative shall counsel a case to abstain from sexual contact until lesions are healed.

Historical Note
Renumbered from R9-6-723 and amended effective October 19, 1993 (Supp. 93-4). Section R9-6-330 renumbered to R9-6-333; new Section R9-6-330 renumberred from R9-6-327 effective April 4, 1997 (Supp. 97-2).

R9-6-331. Human Immunodeficiency Virus (HIV) Infection and Related Disease

A. Reports: As directed by Article 2, a person shall report a case, suspect case, or suspect carrier except for the suspect carrier requesting anonymity pursuant to subsection (D)(4).

B. Case control measures: A health care provider or operator of a blood, plasma center, or milk bank shall not utilize donated blood, plasma, milk, body organs, sperm, or other tissue from a case, suspect case, or suspect carrier for transfusion, transplantation, or consumption.

C. Environmental control measures: The diagnosing health care provider or authorized representative shall ensure concurrent disinfection of equipment or other surfaces contaminated with blood, semen, vaginal fluids, or other body fluids containing visible blood of cases, suspect cases, or suspect carriers.

D. Special control measures:
1. Any physician, hospital administrator, or other person, including operators of blood or plasma centers, tissue or sperm banks, who orders, administers or interprets as positive a test for HIV or antibodies to the virus shall, in addition to meeting the reporting requirements specified, use all reasonable means to notify the person on whom the test was performed within 30 days of receiving the test result.
2. At the time of notification, the physician, hospital administrator or other person shall provide or arrange for counseling which includes factual information regarding the virus, the syndrome and its symptoms, measures which are effective in reducing the likelihood of transmitting the virus to others, the need to notify sex and/or needle-sharing partners of their exposure to the virus and the availability of assistance from local health agencies in partner notification procedures.
3. The local health agency shall conduct or direct an epidemiologic investigation of each reported case, suspected case, or suspect carrier within 30 days of the initial report. Upon completion of the epidemiologic investigation, the local health department shall not retain any personal identifying information on the case, suspect case, or suspect carrier.
4. Counseling and testing sites supervised by the Department or by local health agencies shall offer an anonymous testing option. Epidemiologic information including age, race, sex, county of residence, and associ-

ated risk behaviors shall be collected on individuals opting for anonymous testing.

5. The Department shall confidentially notify an identifiable 3rd party reported to be at risk of HIV infection pursuant to A.R.S. § 36-664(K) if all of the following conditions are met:
   a. The report of risk is made to the Department in writing and includes the name and address of the identifiable 3rd party, the name and address of the person placing the identifiable 3rd party at risk, the type of exposure placing the identifiable 3rd party at risk, and the name and address of the person making the report;
   b. The report is made by a person in possession of confidential HIV-related information;
   c. The Department determines that the above information is both accurate and sufficient to warrant notification of the 3rd party at risk.
6. The local health department shall notify the school district superintendent in a writing which shall be kept confidential that a school district pupil is reported as a case, suspect case, or suspect carrier of HIV infection when all of the following criteria are met:
   a. The infected pupil places others in the school setting at risk for HIV infection. The local health department shall make this determination in consultation with the Department.
   b. The school district has established a communicable disease policy which consists of the following criteria:
      i. A school shall not exclude an infected pupil from school or school functions solely due to HIV infection.
      ii. The school district superintendent, the pupil, or parents or legal guardians of a minor pupil, the pupil's physician, and the local health officer shall make decisions regarding the educational setting for HIV-infected pupils on a case-by-case basis. In addition to the aforementioned individuals, the school district superintendent may also include the following individuals in this decision-making process: the school administrator, school nurse, and principal teacher or counselor. In making this decision, these individuals shall consider the risks and benefits to the pupil and others of maintaining the pupil in the school setting.
      iii. School district personnel informed of the pupil's HIV infection shall maintain that information as confidential.
      iv. School district personnel who handle blood or body fluids shall comply with the "Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and other Bloodborne Pathogens in Health Care Settings", June 1988, Centers for Disease Control, 1600 Clifton Road, N.E., Atlanta, GA 30333, incorporated by reference and no other amendments and on file with the Office of the Secretary of State.
      v. AIDS educational programs shall be made available to pupils, parents, and staff through age-appropriate curricula, workshops, or in-service training sessions.

Historical Note

Renumbered from R9-6-724 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-331 renumbered to R9-6-334; new Section R9-6-331 renumbered from R9-6-328 effective April 4, 1997 (Supp. 97-2).

R9-6-332. Human T-cell Lymphotropic Virus (HTLV-I/II) Type I and II Infection

A. Case control measures: A health care provider or operator of a blood or plasma center shall not utilize donated blood, plasma, milk, body organs, sperm, or other tissue from a case or carrier for transfusion or transplantation.

B. Special control measures: Any person operating a blood or plasma center who interprets as positive a test for the HTLV-I/II shall, in addition to meeting the reporting requirements specified, notify the person on whom the test was performed within 30 days of receiving the final test results.

Historical Note

Renumbered from R9-6-725 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-332 renumbered to R9-6-335; new Section R9-6-332 renumberd from R9-6-329 effective April 4, 1997 (Supp. 97-2).

R9-6-333. Legionellosis (Legionnaires' Disease)

A. Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak.

B. Environmental control measures: The owner of a water, cooling, or ventilation system which is determined to be a source in an outbreak shall disinfect the system before reusing it.

Historical Note

Renumbered from R9-6-726 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-333 renumbered to R9-6-336; new Section R9-6-333 renumbered from R9-6-330 effective April 4, 1997 (Supp. 97-2).

R9-6-334. Leprosy (Hansen's Disease)

A. Contact control measures: The local health agency shall examine household contacts for signs and symptoms of leprosy at 6-12 month intervals for 3 years after the last contact with an infectious case, or 3 years after the case becomes noninfectious.

B. Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Renumbered from R9-6-727 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-334 renumbered to R9-6-337; new Section R9-6-334 renumbered from R9-6-331 effective April 4, 1997 (Supp. 97-2).

R9-6-335. Leptospirosis

Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Renumbered from R9-6-728 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-335 renumbered to R9-6-338; new Section R9-6-335 renumbered from R9-6-332 effective April 4, 1997 (Supp. 97-2).

R9-6-336. Listeriosis

Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak.

Historical Note
Renumbered from R9-6-729 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-336 renumbered to R9-6-339; new Section R9-6-336 renumbered from R9-6-333 effective April 4, 1997 (Supp. 97-2).

R9-6-337. Lyme Disease
Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note
Renumbered from R9-6-730 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-337 renumbered to R9-6-340; new Section R9-6-337 renumbered from R9-6-334 effective April 4, 1997 (Supp. 97-2).

R9-6-338. Malaria
A. Case control measures: A health care provider shall exclude a case from donating blood or plasma for transfusion.
B. Special control measures:
1. Control of a blood donor - The medical director of a blood collection center shall obtain from a prospective blood donor the following information concerning whether the person:
   a. Has or had malaria; or
   b. Has traveled in, visited, or immigrated from an area endemic for malaria; or
   c. Has taken antimalarial drugs.

   The blood collection center shall not draw blood from any person who affirmatively responds to any of the questions or refuses to supply this information.
2. The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note
Renumbered from R9-6-731 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-338 renumbered to R9-6-341; new Section R9-6-338 renumbered from R9-6-335 effective April 4, 1997 (Supp. 97-2).

R9-6-339. Measles (Rubeola)
A. Case control measures: An administrator or authorized representative of a school, child care center, or preschool shall exclude a case from the school, child care center, or preschool and school-sponsored events from the onset of illness through the 4th day after the rash appears. An administrator of a hospital or authorized representative shall isolate a hospitalized case from onset of illness through the 4th day after the rash appears.
B. Contact control measures:
1. Unless able to provide evidence of immunity to measles in accordance with R9-6-703, an administrator or authorized representative of a school, child care center, or preschool shall consult with the local health agency to determine who shall be excluded and the how long they shall be excluded.
2. The local health agency shall provide or arrange for immunization of non-immune individuals within 72 hours of last exposure.

C. Outbreak control measures: An administrator or authorized representative of a school, child care center, or preschool shall consult with the local health agency to determine who shall be excluded and how long they shall be excluded during an outbreak.
D. Special control measures:
1. No employee of any health care facility shall have direct contact with any measles patient, including suspect cases, unless able to provide evidence of immunity to measles.
   a. Evidence of immunity to measles shall consist of:
      i. A record of immunization against measles with 2 doses of live virus vaccine given on or after the 1st birthday and 1 month or more apart; or
      ii. A statement signed by a licensed physician, or a state or local health officer which affirms serologic evidence of having had measles.
   b. Anyone born prior to January 1, 1957 shall be considered to be immune to measles.
2. The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note
Renumbered from R9-6-732 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-339 renumbered to R9-6-342; new Section R9-6-339 renumbered from R9-6-336 and amended effective April 4, 1997 (Supp 97-2).

R9-6-340. Meningococcal Invasive Disease
A. Reports: A report of invasive disease includes meningitis, bacteremia, and septic arthritis.
B. Case control measures: The diagnosing health care provider, an administrator of a hospital, or authorized representative shall isolate a hospitalized case for 24 hours after the initiation of treatment.
C. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.
D. Contact control measures: The local health agency shall evaluate and, if indicated, provide or arrange for prophylaxis of contacts.
E. Special control measures: The local health agency shall conduct or direct as epidemiologic investigation of each reported case.

Historical Note
Renumbered from R9-6-733 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-340 renumbered to R9-6-343; new Section R9-6-340 renumbered from R9-6-337 effective April 4, 1997 (Supp. 97-2).

R9-6-341. Mumps
A. Case control measures: An administrator or authorized representative of a school, child care center, or preschool shall exclude a case from the school, day care center, or preschool for 9 days following the onset of glandular swelling. A health care provider shall use droplet precautions for 9 days following the onset of glandular swelling.
B. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.

Historical Note
Renumbered from R9-6-734 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-341 renumbered to R9-6-344; new Section R9-6-341 renumbered from R9-6-338 and amended effective April 4, 1997 (Supp. 97-2).

R9-6-342. Pediculosis (Lice Infestation)

A. Reports: An administrator or authorized representative of a public or private school, child care center, or preschool shall report an outbreak of pediculosis.

B. Case control measures: An administrator or authorized representative of a school, child care center, or preschool shall exclude a case from the school, child care center, or preschool until treatment for pediculosis is initiated.

C. Outbreak control measures: An administrator or authorized representative of a school, child care center, or preschool shall consult with the local health agency to determine who shall be excluded and how long they shall be excluded during an outbreak.

D. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfestation of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.

Historical Note

Renumbered from R9-6-735 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-342 renumbered to R9-6-345; new Section R9-6-342 renumbered from R9-6-339 and amended effective April 4, 1997 (Supp. 97-2).

R9-6-343. Pertussis (Whooping Cough)

A. Case control measures: An administrator or authorized representative of a school, child care center, or preschool shall exclude a case from the school, child care center, or preschool for 21 days after the date of onset of the illness, or for 5 days following the date of initiation of treatment for pertussis. A health care provider shall use droplet precautions for a hospitalized case for 5 days following the date of initiation of treatment.

B. Contact control measures: The local health agency shall evaluate household contacts for exposure and, if indicated, provide or arrange for prophylaxis.

C. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.

D. Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Renumbered from R9-6-736 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-343 renumbered to R9-6-346; new Section R9-4-343 renumbered from R9-6-340 and amended effective April 4, 1997 (Supp. 97-2).

R9-6-344. Plague

A. Case control measures:

1. A hospital shall use droplet precautions for a case of pneumonic plague until 3 full days of clinically effective antibiotic therapy have been completed.
2. Clothing and personal articles shall be disinfested of fleas with an insecticide approved and labeled for use against fleas.

B. Contact control measures: The local health agency shall provide follow-up of contacts of cases of pneumonic plague for 7 days.

C. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.

D. Special control measures:

1. Persons handling bodies of deceased cases shall observe universal and respiratory precautions.
2. The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Renumbered from R9-6-737 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-344 renumbered to R9-6-347; new Section R9-6-344 renumbered from R9-6-341 and amended effective April 4, 1997 (Supp. 97-2).

R9-6-345. Poliomyelitis

A. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.

B. Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Renumbered from R9-6-738 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-345 renumbered to R9-6-348; new Section R9-6-345 renumbered from R9-6-342 and amended effective April 4, 1997 (Supp. 97-2).

R9-6-346. Psittacosis (Ornithosis)

A. Environmental control measures:

1. The local health agency shall cause infected bird populations to be treated or destroyed and any contaminated structures disinfected.
2. The health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.

B. Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Renumbered from R9-6-739 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-346 renumbered to R9-6-349; new Section R9-6-346 renumbered from R9-6-343 effective April 4, 1997 (Supp. 97-2).

R9-6-347. Q Fever

Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Renumbered from R9-6-740 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-347 renumbered to R9-6-350; new Section R9-6-347 renumbered from R9-6-344 effective April 4, 1997 (Supp. 97-2).

R9-6-348. Rabies in Humans

A. Case control measures: A health care provider or operator of a blood or plasma center shall not utilize donated blood, plasma, body organs, sperm or other tissue from a case, suspect case or suspect carrier for transfusion or transplantation.

B. Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Renumbered from R9-6-741 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-348 renumbered to R9-6-351; new Section R9-6-348 renumbered from R9-6-345 and amended effective April 4, 1997 (Supp. 97-2).

R9-6-349. Relapsing Fever (Borreliosis)

Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Renumbered from R9-6-742 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-349 renumbered to R9-6-352; new Section R9-6-349 renumbered from R9-6-346 effective April 4, 1997 (Supp. 97-2).

R9-6-350. Reye Syndrome

Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Renumbered from R9-6-743 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-350 renumbered to R9-6-353; new Section R9-6-350 renumbered from R9-6-347 effective April 4, 1997 (Supp. 97-2).

R9-6-351. Rocky Mountain Spotted Fever

Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Renumbered from R9-6-744 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-351 renumbered to R9-6-354; new Section R9-6-351 renumbered from R9-6-348 effective April 4, 1997 (Supp. 97-2).

R9-6-352. Rubella (German Measles)

A. Case control measures: An administrator or authorized representative of a school shall exclude a case from the school, child care center, or preschool from the onset of illness through the 4th day after the rash appears. An administrator of a hospital or authorized representative shall isolate a hospitalized case.

B. Outbreak control measures: An administrator or authorized representative of a school, child care center, or preschool shall exclude non-immune persons from the school, child care center, or preschool during an outbreak.

C. Special control measures:

1. No employee of any health care facility shall have direct contact with any rubella patient, including suspect cases, or with any patient who is or may be pregnant unless able to provide evidence of immunity to rubella. Evidence of immunity to rubella shall consist of:
   a. A record of immunization against rubella given on or after the 1st birthday; or
   b. A statement signed by a licensed physician, or a state or local health officer which affirms serologic evidence of having had rubella.
2. The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Renumbered from R9-6-745 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-352 renumbered to R9-6-355; new Section R9-6-352 renumbered from R9-6-349 effective April 4, 1997 (Supp. 97-2).

R9-6-353. Rubella Syndrome, Congenital

A. Case control measures: An administrator of a hospital or its authorized representative shall isolate a case under 1 year of age until a negative virus culture is obtained.

B. Special control measures:

1. No employee of any health care facility who is known to be pregnant shall have direct contact with any congenital rubella syndrome patient, including suspect cases, unless able to provide evidence of immunity to rubella in accordance with R9-6-349(C).
2. The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Renumbered from R9-6-746 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-353 renumbered to R9-6-356; new Section R9-6-353 renumbered from R9-6-350 effective April 4, 1997 (Supp. 97-2).

R9-6-354. Salmonellosis

A. Case control measures: The local health agency shall exclude a case with symptoms of salmonellosis from handling food, attending child care, caring for children in child care or preschools, or caring for patients in nursing homes until either of the following occurs:

1. Two successive negative stool cultures are obtained from specimens collected 24 hours or more apart, or
2. Symptoms are absent.

B. Contact control measures: The local health agency shall exclude contacts with symptoms of salmonellosis from working as food handlers until either of the following occurs:

1. Two successive negative stool cultures are obtained from specimens collected 24 hours or more apart, or
2. Symptoms are absent.

C. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.

D. Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak.

Historical Note

Renumbered from R9-6-748 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-354 renumbered to R9-6-357; new Section R9-6-354 renumbered from R9-6-351 and amended effective April 4, 1997 (Supp. 97-2).

R9-6-355. Scabies

A. Reports: An administrator or authorized representative of a public or private school, child care center, preschool, or nursing home shall report an outbreak of scabies.

B. Case control measures: An administrator or authorized representative of a public or private school, child care center, preschool, or nursing home shall exclude a case from school, child care center, or preschool or from having direct patient contact until treatment for scabies is initiated.
C. Contact control measures: An administrator or authorized representative of a school, child care center, preschool, or nursing home shall refer a household contact for examination and treatment.
D. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about concurrent sanitary disposal or disinfestation of the clothing and bedding. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.
E. Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak, shall provide education and consultation regarding prevention, control, and treatment pursuant to subsections (A), (B), and (C), and, when in a health care facility, shall notify the licensing agency of the outbreak.

Historical Note
Renumbered from R9-6-749 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-355 renumbered to R9-6-358; new Section R9-6-355 renumbered from R9-6-352 effective April 4, 1997 (Supp. 97-2).

R9-6-356. Shigellosis
A. Case control measures:
1. The local health agency shall exclude a case with symptoms of shigellosis from handling food, caring for children in child care centers or preschools, or caring for patients in nursing homes until either of the following occurs:
   a. Two successive negative stool cultures are obtained from specimens collected 24 hours or more apart, and 48 hours or more after discontinuing antibiotics; or
   b. Treatment is maintained for 24 hours and symptoms are absent.
2. The diagnosing health care provider or authorized representative shall counsel a case regarding the importance of proper handwashing to prevent transmission.

B. Contact control measures: The local health agency shall exclude a contact with symptoms of shigellosis from handling food, caring for children in child care centers or preschools, and caring for patients in nursing homes until 2 successive negative stool cultures are obtained from specimens collected 24 hours or more apart. If either culture is positive, the contact shall be considered a case or carrier.
C. Environmental control measures: The health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.
D. Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak.

Historical Note
Former Section R9-6-115, Paragraph (38), renumbered and amended as R9-6-750 effective January 28, 1987 (Supp. 87-1). Renumbered from R9-6-750 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-356 renumbered to R9-6-360; new Section R9-6-356 renumbered from R9-6-353 and amended effective April 4, 1997 (Supp. 97-2).

R9-6-357. Staphylococcal Skin Disease
A. Case control measures: A hospital shall exclude a case with staphylococcal lesion from providing direct patient care in health care facilities and food handling. A hospital nursery shall isolate a case.
B. Contact control measures: An administrator of a hospital or health care facility, or an authorized representative, shall isolate a case or, during an outbreak, may group cases colonized with the same organism together.
C. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.
D. Special control measures: In a hospital nursery outbreak, a hospital administrator or authorized representative shall exclude a health care provider from the nursery until the health care provider is examined and found not to carry the epidemic strain or the cases are discharged.

Historical Note
Adopted effective October 19, 1993 (Supp. 93-4). Former Section R9-6-357 renumbered to R9-6-361; new Section R9-6-357 renumbered from R9-6-354 and amended effective April 4, 1997 (Supp. 97-2).

R9-6-358. Streptococcal Disease and Invasive Group A Streptococcal Disease
A. Case control measures: The local health agency shall exclude a case with streptococcal lesions or streptococcal sore throat from food handling or attending school or child care for 24 hours after the initiation of treatment for streptococcal disease.
B. Outbreak control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported outbreak.
C. Special control measures: The local health agency shall complete an investigation of each case of invasive group A streptococcal disease using a form provided by the Department.

Historical Note
Former Section R9-6-115, Paragraph (39), renumbered and amended as R9-6-751 effective January 28, 1987 (Supp. 87-1). Renumbered from R9-6-751 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-358 renumbered to R9-6-362; new Section R9-6-358 renumbered from R9-6-355 and amended effective April 4, 1997 (Supp. 97-2).

R9-6-359. Streptococcal Group B Invasive Disease in Infants Less Than 30 Days of Age
Special control measures: The local health agency shall complete an investigation of each case of invasive group B streptococcal disease using a form provided by the Department.

Historical Note
Adopted effective January 28, 1987 (Supp. 87-1). Renumbered from R9-6-752 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-359 renumbered to R9-6-363; new Section R9-6-359 adopted effective April 4, 1997 (Supp. 97-2).

R9-6-360. Syphilis
A. Case control measures: A case shall be subject to serologic testing at 3 and 6 months following initiation of treatment. A health care provider or operator of a blood or plasma center shall not utilize blood, plasma, sperm, body organs, or tissue

from a case for transfusion or transplantation. The diagnosing health care provider or authorized representative shall counsel the case to abstain from sexual contact for 7 days after completion of treatment.

B. Contact control measures: The local health agency shall identify and offer serologic testing and treatment to sexual contacts.

C. Special control measures:

1. Any person operating a blood or plasma center who interprets a positive test for the syphilis antigen or antibody shall, in addition to meeting the reporting requirements specified, notify or cause to be notified the person on whom the test was performed within 30 days of interpreting the test.
2. The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Former Section R9-6-115, Paragraph (40), renumbered and amended as R9-6-753 effective January 28, 1987 (Supp. 87-1). Renumbered from R9-6-753 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-360 renumbered to R9-6-364; new Section R9-6-360 renumbered from R9-6-356 and amended effective April 4, 1997 (Supp. 97-2).

R9-6-361. Taeniasis

A. Case control measures: The local health agency shall exclude a food handler or a student with *Taenia solium* from handling food or attending a child care center until free of infestation.

B. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.

Historical Note

Former Section R9-6-115, Paragraph (41), renumbered and amended as R9-6-754 effective January 28, 1987 (Supp. 87-1). Renumbered from R9-6-754 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-361 renumbered to R9-6-365; new Section R9-6-361 renumbered from R9-6-357 effective April 4, 1997 (Supp. 97-2).

R9-6-362. Tetanus

Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Former Section R9-6-115, Paragraph (42), renumbered and amended as R9-6-755 effective January 28, 1987 (Supp. 87-1). Renumbered from R9-6-755 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-362 renumbered to R9-6-366; new Section R9-6-362 renumbered from R9-6-358 effective April 4, 1997 (Supp. 97-2).

R9-6-363. Toxic Shock Syndrome

Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Former Section R9-6-115, Paragraph (43), renumbered and amended as R9-6-756 effective January 28, 1987 (Supp. 87-1). Renumbered from R9-6-756 and amended effective October 19, 1993 (Supp. 93-4). Section R9-6-363 renumbered to R9-6-367; new Section R9-6-363 renumbered from R9-6-359 effective April 4, 1997 (Supp. 97-2).

R9-6-364. Trichinosis

Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Former Section R9-6-115, Paragraph (44), renumbered and amended as R9-6-757 effective January 28, 1987 (Supp. 87-1). Renumbered from R9-6-757 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-364 renumbered to R9-6-368; new Section R9-6-364 renumbered from R9-6-360 effective April 4, 1997 (Supp. 97-2).

R9-6-365. Tuberculosis

A. Case control measures: A hospital shall isolate a pulmonary or laryngeal case in a room with special ventilation until 3 sputum smears are negative for acid fast bacilli, treatment for tuberculosis is initiated, and the case is no longer coughing.

B. Contact control measures: Contacts shall be subject to Mantoux tuberculin testing with purified protein derivative (PPD). The local health agency shall arrange for tuberculin skin testing of a contact not known to have tuberculosis infection. If negative, the local health agency shall arrange for a retest 3 months after the 1st skin test.

C. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.

D. Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Former Section R9-6-115, Paragraph (4), renumbered and amended as R9-6-758 effective January 28, 1987 (Supp. 87-1). Renumbered from R9-6-758 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-365 renumbered to R9-6-372; new Section R9-6-365 renumbered from R9-6-361 effective April 4, 1997 (Supp. 97-2).

R9-6-366. Tularemia

A. Case control measures: A hospital shall isolate a case of pneumonic tularemia for 48 hours after the initiation of treatment.

B. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.

C. Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note

Former Section R9-6-115, Paragraph (46), renumbered and amended as R9-6-759 effective January 28, 1987 (Supp. 87-1). Renumbered from R9-6-759 and amended effective October 19, 1993 (Supp. 93-4). Former Section R9-6-366 renumbered to R9-6-374; new Section R9-6-366 renumbered from R9-6-362 effective April 4, 1997 (Supp. 97-2).

R9-6-367. Typhoid Fever

A. Case control measures: The local health agency shall exclude a case from handling food and caring for children in child care

centers or preschools until 1 month or more after the date of onset of the illness and 3 successive negative stool cultures have been obtained from specimens collected 24 hours or more apart and 48 hours or more after cessation of antibiotic therapy. If 1 culture is positive, the exclusions shall be enforced until 3 successive negative stool cultures are obtained from specimens collected 1 month or more apart, and 12 months or less after the date of onset of the illness. If a positive stool culture is obtained on a specimen collected 12 months or more after onset, the case shall be designated a carrier.

B. Contact control measures: The local health agency shall exclude a contact from handling food and caring for children in child care centers or preschools until 2 successive negative stool cultures are obtained from specimens collected 24 hours or more apart. If either culture is positive, the contact shall be considered to be a case.

C. Environmental control measures: The diagnosing health care provider or authorized representative shall counsel a case about handwashing and concurrent disinfection of contaminated articles. In the event the case is a child or incapacitated adult, a health care provider shall counsel the person responsible for care.

D. Special control measures:

1. A local health officer shall not exclude a carrier from food handling when 3 negative stool cultures are obtained from specimens collected 1 month or more apart and no contact is symptomatic during this time. One of the 3 specimens shall be obtained by purging.
2. Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note
Section R9-6-367 renumbered from R9-6-363 effective April 4, 1997 (Supp. 97-2).

R9-6-368. Typhus Fever: Flea-borne
Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note
Section R9-6-368 renumbered from R9-6-364 effective April 4, 1997 (Supp. 97-2).

R9-6-369. Vancomycin Resistant *Entercoccus* sp.
Case control measures: An administrator or authorized representative of a hospital or health care facility shall implement contact isolation for patients with suspected vancomycin resistant *Enterococcus* sp.

Historical Note
Adopted effective April 4, 1997 (Supp. 97-2).

R9-6-370. Vancomycin Resistant *Staphylococcus aureus*
Case control measures: An administrator or authorized representative of a hospital or health care facility shall implement contact isolation for patients with suspected vancomycin resistant *Staphylococcus aureus*.

Historical Note
Adopted effective April 4, 1997 (Supp. 97-2).

R9-6-371. Vancomycin Resistant *Staphylococcus epidermidis*
Case control measures: An administrator or authorized representative of a hospital or health care facility shall implement contact isolation for patients with suspected vancomycin resistant *Staphylococcus epidermidis*.

Historical Note
Adopted effective April 4, 1997 (Supp. 97-2).

R9-6-372. Varicella (Chickenpox)
Case control measures: An administrator or authorized representative of a school, child care center, or preschool shall exclude a case from school, child care center, or preschool until lesions are dry and crusted. A hospital shall use airborne precautions for a case.

Historical Note
Section R9-6-372 renumbered from R9-6-365 and amended effective April 4, 1997 (Supp. 97-2).

R9-6-373. Vibrio Infection
Special control measures: The local health agency shall complete an investigation of each case of *Vibrio* infection using a form provided by the Department.

Historical Note
Adopted effective April 4, 1997 (Supp. 97-2).

R9-6-374. Yellow Fever
Special control measures: The local health agency shall conduct or direct an epidemiologic investigation of each reported case.

Historical Note
Section R9-6-374 renumbered from R9-6-366 effective April 4, 1997 (Supp. 97-2).

R9-6-375. Yersiniosis
Special control measures: The local health agency shall complete an investigation of each case of yersinosis using a form provided by the Department.

Historical Note
Adopted effective April 4, 1997 (Supp. 97-2).

ARTICLE 4. HUMAN IMMUNODEFICIENCY VIRUS (HIV) / ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

R9-6-401. Limitations and Termination of Program

A. This program shall provide zidovudine and any other drug which has been determined by the FDA to prolong the life of a person with AIDS or related conditions to the extent of funding made available for that purpose.

B. Therapeutic assistance shall be available only to certain low-income individuals not covered under AHCCCS or by any third-party payor.

C. Therapeutic assistance shall be allocated to the maximum number of eligible persons derived by dividing the available funds by the cost of treatment for one person with zidovudine or other life-prolonging drug for a period concurrent with and ending in accordance with the fiscal year for which such funds are authorized. All others shall be placed on a waiting list; the Department may revise the maximum number of persons upward or downward, according to its actual experience with the availability of the therapeutic agent. Those on the waiting list shall have therapeutic assistance afforded them only if the maximum number of persons is raised or one or more persons receiving assistance leave the program. Upon the occurrence of such vacancy, the person at the top of the waiting list shall be enrolled for the period of time remaining in the fiscal year.

D. All therapeutic assistance shall terminate upon the exhaustion or termination of available funding expressly authorized for this purpose. This program shall not constitute an entitlement program for any person or create a right to assistance absent continued available funding.

Historical Note
Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant

to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Amended and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted without change as an emergency effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Adopted without change as a permanent rule effective May 22, 1989. Amended as an emergency effective June 26, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Emergency amendment readopted without change effective October 17, 1989 (Supp. 89-4). Amended effective September 19, 1990 (Supp. 90-3). Renumbered from R9-6-801 effective October 19, 1993 (Supp. 93-4).

R9-6-402. Eligibility

A. To establish financial eligibility, an applicant shall comply with the following:
1. Provide a copy of one of the following:
   a. Application for eligibility determination as filed with AHCCCS or SSI, bearing their stamp of the date processed, for which a determination of eligibility has not yet been made; or
   b. Letter denying eligibility under AHCCCS or SSI.
2. Certify that no health insurance is in effect for the applicant which covers the cost of the therapeutic agents that are or may become available under this Article on an outpatient basis.
3. To establish financial eligibility for HIV/AIDS therapy assistance, income shall not exceed the following allowable family income levels:

ALLOWABLE INCOME LIMITS

Size of Family Unit	Upper Limit Annual Income
1	$13,240
2	$17,760
3	$22,280
4	$26,800
5	$31,320
6	$35,840
7	$40,360
8	$44,880

B. To establish medical eligibility, an applicant 13 years of age or over shall have one of the following conditions:
1. A medical history of cytologically confirmed *Pneumocystis carinii* pneumonia, or
2. A diagnosis of HIV infection which includes serologic or virologic evidence of HIV infection and an absolute CD_4 (T4 helper/inducer) lymphocyte count of less than 500/mm^3 in the peripheral blood before the initiation of therapy.

C. To establish medical eligibility, an applicant more than three months but less than 13 years of age shall have one of the following conditions:
1. A diagnosis of HIV-related illness, or
2. A diagnosis of HIV infection with laboratory values indicating HIV-related immunosuppression.

D. The applicant shall be a resident of Arizona.

Historical Note

Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Amended and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted without change as an emergency effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Adopted without change as a permanent rule effective May 22, 1989 (Supp. 89-2). Amended effective September 19, 1990 (Supp. 90-3). Amended as an emergency effective August 8, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency expired. Emergency amendments re-adopted without change effective November 19, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-4). Emergency expired. Emergency amendments re-adopted without change effective February 28, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-1). Emergency expired. Renumbered from R9-6-802 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-403. Application Process

A. Application shall be made on a form prescribed by the Department containing the following:
1. Personal and other information.
   a. Name, date of birth, sex;
   b. Address;
   c. Telephone number;
   d. Number of persons in household;
   e. Income; and
   f. The identification number, if a subject in the clinical trial study of zidovudine.
2. Medical information.
   a. A medical history of cytologically confirmed *Pneumocystis carinii* pneumonia; or
   b. A confirmed diagnosis of symptomatic HIV infection, and evidence that the applicant's CD_4 (T4 helper/inducer) lymphocyte count is above or below 400/mm^3 in the peripheral blood prior to the initiation of therapy, the date of testing, and the name and address of the laboratory performing the testing; and
   c. The name, address and telephone number of the applicant's physician.
3. Certification statements.
   a. The applicant, or the applicant's parent, if the applicant is a minor, or legal guardian shall certify the following:
      "I,_____, certify that to the best of my knowledge and belief, all statements made herein regarding personal and other non-medical information are true and accurate. I certify that I am or my child or ward is not covered by any health insurance plan that would provide the support for which I am or my child or ward is applying. I understand that eligibility does not guarantee that the Arizona Department of Health Services will be able to provide support and that such support, if begun, may be terminated without notice."
   b. The applicant's physician shall sign the certificate attesting to the following:
      "I certify that to the best of my knowledge and belief all medical information presented by me in this application is true and accurate."
   c. Failure by the applicant or the physician to provide the certification shall result in a denial of eligibility by the Department.

B. As a part of, and appended to the prescribed application form, the applicant shall present documentation for benefits from AHCCCS or SSI pursuant to R9-6-402(A)(1).

Historical Note
Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Amended and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted without change as an emergency effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Amended Subsection (B) and adopted as a permanent rule effective May 22, 1989 (Supp. 89-2). Amended as an emergency effective August 8, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency expired. Emergency amendments re-adopted without change effective November 19, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-4). Emergency expired. Emergency amendments re-adopted without change effective February 28, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-1). Emergency expired. Renumbered from R9-6-803 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-404. Eligibility Determination and Enrollment Process

A. The Department shall review each application for completeness, for the certifications by both the applicant and the physician, and the application for benefits from either AHCCCS or SSI. The Department may seek to verify any and all information submitted in or in support of the application prior to or after a determination of eligibility. Applicants shall be required, upon request by the Department, to produce any reasonable documentation relating to eligibility. Failure to provide such documentation or provision of false or inaccurate information shall be grounds for denial of eligibility. If all portions are determined to be accurate, true and complete, if the certifications are present, and if the eligibility standards set forth in R9-6-402 are met, the applicant shall be declared eligible.

B. All applications shall be reviewed, and have an eligibility determination made, if all necessary documentation is included, at the time of receipt by the Department. If a slot is available for enrollment and support, the eligible person shall be enrolled. If none is available, the eligible person shall be placed on the waiting list. Enrollment or placement on the waiting list shall be in the order the applications are received, except that clinical trial study subjects shall be given priority over other eligible persons.

C. The Department shall notify, in writing, both the applicant and the physician of the declaration of or denial of eligibility.

Historical Note
Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Amended and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted as an emergency and Subsection (A) corrected effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Amended Subsection (B) and adopted as a permanent rule effective May 22, 1989 (Supp. 89-2). Renumbered from R9-6-804 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-405. Period of Eligibility

A. Eligibility shall continue for one year subject to a six-month review from the date of determination, unless one of the following events occur ending the eligibility period immediately:
1. Death of the eligible person;
2. Use of the therapeutic agent is halted on the advice of the physician;
3. Determination of eligibility and enrollment to receive medical services through either AHCCCS or SSI;
4. Increase in income above the allowable level; or
5. Establishment of residence outside Arizona. The eligible person or the person's physician shall notify the Department within 30 days of the occurrence of any of these events.

B. The review at six months shall be based upon the submission of a follow-up application by the eligible person on a form prescribed by the Department. Failure to provide the follow-up application shall result in a denial of further eligibility by the Department. The form shall contain the following:
1. Name, address, and telephone number;
2. Status of the application made to SSI or to AHCCCS since the Department's determination of eligibility;
3. Current annual income;
4. Recertification utilizing the statement specified in R9-6-403(A)(3)(a);
5. Physician's statement that treatment with the therapeutic agent is still appropriate; and
6. A recertification by the physician with the statement specified in R9-6-403(A)(3)(b).

Historical Note
Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Amended and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted as an emergency and Subsection (B), Paragraph (2) corrected effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Adopted without change as a permanent rule effective May 22, 1989 (Supp. 89-2). Renumbered from R9-6-805 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-406. Distribution Requirements

A. The physician shall submit to the Department an order on the physician's prescription form for one month's supply of the therapeutic agent for each enrolled person who is under the care of the physician. Each prescription shall be refillable a maximum of five times.

B. The Department shall purchase the therapeutic agent and provide it to the enrolled person's physician in quantities sufficient to meet the therapeutic regimen prescribed by the physician.

C. The Department shall provide the therapeutic agent in original, unopened containers as supplied by its vendor.

D. In the event the care of an enrolled person is transferred to another physician, the original physician shall notify the Department within five working days of the transfer. The following information shall be provided:
1. Name and address of the enrolled person;

2. Name, address, and telephone number of physician to whom care is transferred; and
3. A release signed by the patient authorizing the Department to contact and exchange information with the physician to whom care is transferred. Failure to comply may cause an interruption in or termination of support.

Historical Note

Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Amended and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted without change as an emergency effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Adopted without change as a permanent rule effective May 22, 1989 (Supp. 89-2). Amended effective September 19, 1990 (Supp. 90-3). Renumbered from R9-6-806 effective October 19, 1993 (Supp. 93-4).

R9-6-407. Appeal

A. The provisions of this Section shall be applicable to applicants and eligible persons adversely affected by an action regarding eligibility.

B. An applicant may seek review of any decision regarding eligibility by filing a written appeal with the assistant director of the Division of Disease Prevention no more than 20 days from the date of receipt of the eligibility decision.

C. The assistant director shall review the eligibility decision and, within ten days of the filing of the appeal, shall mail the written determinations to the applicant. The determination shall include a statement regarding the right of the applicant to appeal to the Director, within 20 days of receipt of the assistant director's written determination, pursuant to A.A.C. R9-1-111 through R9-1-126.

D. Any appeal made to the Director following the review by the assistant director shall constitute a waiver of the applicant's confidentiality, but solely for the purpose of the administrative proceeding.

Historical Note

Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Emergency not renewed. Former Section R9-6-808 renumbered as Section R9-6-807, amended, and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted as an emergency and Subsection (C) corrected effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Adopted without change as a permanent rule effective May 22, 1989 (Supp. 89-2). Renumbered from R9-6-807 effective October 19, 1993 (Supp. 93-4).

R9-6-408. Confidentiality

The application materials and all information received or maintained by the Department in connection with application for support and subsequent actions shall be considered as confidential medical information. The provisions of A.A.C. R9-1-311 et seq. shall govern the Department with regard to these materials and information.

Historical Note

Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Former Section R9-6-809 renumbered as Section R9-6-808, amended and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted without change as an emergency effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Adopted without change as a permanent rule effective May 22, 1989 (Supp. 89-2). Renumbered from R9-6-808 effective October 19, 1993 (Supp. 93-4).

R9-6-409. Consent for HIV-related Testing

A. A person ordering a HIV-related test shall obtain consent for the test, unless ordered by the court under A.R.S. § 13-1415(B). If the test is ordered in a hospital, specific written informed consent is required. If the test is ordered outside a hospital by a physician licensed pursuant to A.R.S. Title 32, Chapter 13, 17, or 29, a nurse practitioner certified pursuant to A.R.S. Title 32, Chapter 15 or a physician's assistant certified pursuant to A.R.S. Title 32, Chapter 25, the consent shall be either written or oral. If the HIV-related test is performed anonymously, then oral consent is required and no record shall be made with personal identifying information on the patient.

B. Written consent shall be on the form shown in Exhibit A (English) or Exhibit B (Spanish). Individuals and facilities using the consent form may add or affix the following additional information in the Identifying Information section of the form: patient/subject's name and identifying number, facility identifying information, facility processing codes, and patient/subject's date of birth and sex. This form may be reproduced to accommodate a multiple copy or carbonless form.

Editor's Note: The form referred to above (Exhibit A) was not filed with the Department's original rulemaking package (Supp. 93-4). When this Section was amended (Supp. 97-2) both Exhibit A and B were filed with the Office of the Secretary of State and adopted.

Historical Note

Adopted effective October 19, 1993 (Supp. 93-4). Amended effective April 4, 1997 (Supp. 97-2).

Exhibit A. Consent for HIV Testing

Consent for HIV Testing

Information on HIV

The Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immune Deficiency Syndrome (AIDS). HIV is spread through the exchange of blood (including transfusion), sexual fluids (semen and vaginal secretions) and sometimes through breast milk. HIV can be transmitted from mother to baby during pregnancy or childbirth.

HIV Testing

There are several laboratory tests for HIV. The most common is the antibody test, which is a blood test that detects antibodies produced by the body in response to infection with HIV.

A positive antibody test consists of a repeatedly reactive (the same specimen testing positive twice) enzyme immunoassay (EIA) and a reactive Western blot (supplementary test). A positive antibody test means that an individual is infected with HIV; however, this does not always mean that the individual has AIDS. Research indicates that early and regular medical care is important to the health of a person with HIV. Certain treatments are now available to delay HIV-associated illnesses.

A negative antibody test indicates that no detectable antibodies are present in the blood. An individual may not have antibodies because the individual is not infected with HIV or because detectable antibodies have not yet been made in response to infection. The production of these antibodies could take 3 months or longer. Therefore, in certain cases, an individual may be infected with HIV and yet test negative. Individuals with a history of HIV risk behaviors within the past 3 to 6 months should consider retesting.

Like any test, HIV testing is not 100% reliable and may occasionally produce both false positive and false negative results.

Means to Reduce Risk for Contracting or Spreading HIV

Risk of contracting or spreading HIV can be reduced by avoiding or decreasing contact with blood and sexual fluids (semen and vaginal secretions). Some methods of decreasing the risk of contracting or spreading HIV include abstaining from sexual intercourse, using methods that limit exposure to body fluids during intercourse (such as the proper use of condoms), not engaging in injecting drug use, not sharing needles, or using bleach and water to clean needles and syringes. The use of certain medications by a HIV - infected woman during pregnancy may reduce the chances of HIV transmission from mother to child.

Disclosure of Test Results

I understand that if the HIV test results are positive, the physician or facility representative conducting the test will make reasonable efforts to notify me of the results at the address or phone number I have provided, and will provide or arrange for counseling as required by Arizona state laws and regulations regarding (1) the HIV (2) AIDS and (3) appropriate precautions to reduce the likelihood of transmission of the virus to others. I agree to assume all risks that may result if I cannot be contacted.

I understand that Arizona law and regulations require that if my test results are positive, they will be submitted to local and state health departments. Information received by these health departments may only be released (1) if there is written authorization from the person being tested; (2) for statistical purposes without individual identifying information, or as otherwise required or allowed by law.

Identifying Information

I also understand that the physician or facility may report to the Arizona Department of Health Services identifiable 3rd parties such as a spouse or sex partner who may be at risk of contracting the virus if I do not release this information. Finally, I understand that the test results may be placed in a medical record kept by the facility or person administering the test and that persons involved in providing or paying for my health care may have access to that information.

Additional Sources of Information on HIV

Additional information regarding testing for HIV is available through your county health department and, in the Phoenix metropolitan area, (602) 234-2752, the Tucson metropolitan area, (520) 326-2437, or outside the Phoenix area, 1-800-334-1540. National Hotline: English, 1-800-342-2437; Spanish, 1-800-344-7432; TTY/TDD, 1-800-243-7012.

Consent

I have been given the opportunity to ask questions regarding this information and have had my questions answered to my satisfaction. I understand that this test can be performed anonymously at a public health agency. I also understand that I may withdraw my consent at any time before a blood sample is taken in order to conduct a test, and that I may be asked to put my decision to withdraw my consent in writing if I have signed this consent. I also understand that this is a voluntary test and that I have a right to refuse to be tested.

My signature below indicates that I have received and understand the information I have been given and I voluntarily consent to and request HIV testing.

_____

Patient/Subject Name (Printed)

_____

Patient/Subject or Legal Representative Signature

_____

Date

_____

Witness

NOTICE

The Arizona Department of Health Services does not discriminate on the basis of disability in the administration of its programs and services as prescribed by Title II of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. If you need this publication in an alternative format, please contact the ADHS Office of HIV/STD Services at (602) 230-5819 or 1-800-367-8939 (state TDD/TTY Relay).

Historical Note

Exhibit A "Consent for HIV Testing" (English) form adopted effective April 4, 1997 (Supp. 97-2).

Exhibit B. Consentimiento Para la Prueba de VIH

Consentimiento Para la Prueba de VIH

Información sobre el VIH

El virus de Inmunodeficiencia Humana (VIH) es el virus que causa el Sindrome de Inmunodeficiencia Adquirida (SIDA). VIH se transmite a través del contacto con sangre (incluyendo la transfusión), fluídos sexuales (semen y secreciones vaginales) y en algunas ocaciones a través de la leche materna. VIH puede ser transmitido de la madre al bebé durante el embarazo o al momento del parto.

La prueba del VIH

Existen pruebas de laboratorio para saber si una persona está infectada con el VIH. La más común es la prueba de anticuerpos. Esta es un exámen de sangre que detecta los anticuerpos producidos por el cuerpo al reaccionar contra la infección por VIH.

Un examen de anticuerpos positivo consiste de una prueba por inmunoanálisis enzimático (EIA) (realizada dos veces en cada espécimen) y una prueba reactiva por Western Blot u otras pruebas confirmatorías. El resultado positivo a la prueba de anticuerpos quiere decir que el individuo está infectado con el VIH; sin embargo, esto no siempre quiere decir que el individuo tenga el SIDA. Investigaciones médicas señalan que atención médica temprana y contínua es importante para la salud de una persona con el VIH. Hoy en día se dispone de tratamientos para retardar las enfermedades asociadas con el SIDA.

Un exámen de anticuerpos negativo indica que no se han detectado anticuerpos en la sangre. Un individuo puede no tener anticuerpos por que el individuo no está infectado(a) o porque aún no se han producido suficientes anticuerpos contra la infección. Estos anticuerpos pueden tardar tres meses o más para ser producidos. De tal manera, en ciertos casos, un individuo puede estar infectado con el VIH y su prueba resultar negativa. Los individuos que han tenido comportamiento de alto riesgo en los últimos tres a seis meses deberían pensar en repetir la prueba.

Como cualquier prueba, la prueba del VIH no es 100% segura y en alguna ocasión puede producir resultados falsos ya sea positivos o negativos.

Maneras de reducir el riesgo de infección o transmisión del VIH

El riesgo de contraer o transmitir el VIH se puede reducir al evitar contacto con la sangre y fluídos sexuales (semen y secreciones vaginales). Algunos métodos para disminuir el riesgo de infección o transmisión del VIH incluyen: abstinecia sexual, usar métodos que limitan el contacto de fluídos corporales durante la relaciones sexuales (como el uso correcto de condones), no usar drogas intravenosas, no compartir agujas, y usar “cloro” (blanqueador) y agua para limpiar las jeringas y las agujas. En mujeres infectadas con VIH, el uso de ciertos medicamentos durante el embarazo, puede reducir el riesgo del transmissión del VIH de madre a hijo.

El resultado de la prueba

Entiendo que si el resultado de la prueba del VIH es positivo, el doctor o el representante de la institución que hizo el exámen va a hacer esfuerzos suficientes para notificarme del resultado a la dirección (domicilio) o al teléfono que he proporcionado y que me dará información, cumpliendo con los requisitos de la ley estatal de Arizona, sobre (1) el VIH, (2) el SIDA, y (3) las precauciones necesarias para reducir la posibilidad de transmisión del virus a otras personas. Estoy de acuerdo en asumir todos los riesgos que resultarán de no poder contactarme.

Entiendo que la ley estatal de Arizona exige que si el resultado de mi prueba es positivo, éste se reportará a los departamentos de salud local y estatal. La información que estos departamentos reciben solamente puede ser revelada a otras personas: (1) si hay una autorización por escrito de la persona que se ha hecho la prueba; (2) por razones de estudios estadísticos sin revelar la identidad del individuo, o por cualquier otra razón que la ley permita.

Identifying Information/Datos de Identidad

También entiendo que el doctor o la institución puede reportar al Departamento de Salud del Estado de Arizona, la identidad de terceras personas como: los esposos(as) o los compañeros(as) sexuales que pueden estar en riesgo de contraer con el virus si decido no darles esta información. Por último, entiendo que el resultado de la prueba puede guardarse con el resto de mi información médica en la agencia o por la persona que hizo el examen; y que las personas encargadas de proveer o pagar por el cuidado de mi salud pueden tener acceso a esta información.

Otras fuentes de información sobre el VIH

Información adicional sobre el examen del VIH está disponible a través del departamento de salud de su condado. En el área metropolitana de Phoenix llame al (602) 234-2752, en el área metropolitana de Tucson (520) 326-2437, y en el resto de Arizona 1-800-334-1540. Líneas telefónicas a nivel nacional son: en inglés 1-800-342-2437; en español 1-800-344-7432. (TTY/TDD) Transmisión de voz 1-800-243-7012.

Consentimiento

Se me ha dado la oportunidad de hacer preguntas respecto a esta información y me han sido contestadas satisfactoriamente. Entiendo que este exámen se puede hacer de forma anónima en una agencia de salud pública. También entiendo que puedo retirar mi consentimiento en cualquier momento antes de que me saquen la sangre para hacer la prueba y que me pueden pedir que ponga por escrito mi decisión de retirar mi consentimiento si ya habiá firmado este permiso. Entiendo también que este exámen es voluntario y que tengo el derecho a negarme a que se me haga la prueba.

Mi firma indica que he recibido y he entendido la información que se me ha proporcionado y que voluntariamente autorizo y solicito la prueba del VIH.

_____

Nombre del paciente (letra imprenta)

_____

Firma del paciente o de su representante legal

_____

Fecha

_____

Testigo

AVISO

El Deparamento de Salud del Estado de Arizona no discrimina basado en los impedimentos de las personas en la administración de los progamas y sevicios ordenado por la ley de 1990: Americanos con Impedimentos, Título II y la Sección 504 de la ley de Rehabilitación de 1973. Si usted necesita esta publicación por otros medios de comunicación, favor ponerse en cantacto con el Departamento de Salud del Estado de Arizona, Oficina de Servicios de VIH/ETS al 1-800-842-4681 (transmisión de voz estatal) or 1-800-367-8939 (transmisión TDD/TYY estatal.)

Historical Note

Exhibit B “Consentimiento Para la Prueba de VIH” (Consent for HIV Testing-Spanish) form adopted effective April 4, 1997 (Supp. 97-2).

R9-6-410. Human Immunodeficiency Virus Testing
A blood test performed pursuant to A.R.S. § 13-1415 for antibodies to HIV shall use an enzyme immunoassay test and shall be licensed by the Food and Drug Administration (FDA). Blood that is reactive according to the manufacturer's recommendations shall be retested in duplicate, diluting from the original specimen. Repeatedly reactive blood shall be tested with an FDA-licensed Western blot test. Western blot band patterns shall be interpreted according to the recommendations, "Interpretation and Use of the Western Blot Assay for Serodiagnosis of Human Immunodeficiency Virus Type 1 Infections", Morbidity and Mortality Weekly Report, July 21, 1989, vol. 38, No. S-7, Centers for Disease Control, 1600 Clifton Road, N.E., Atlanta, GA 30333, incorporated herein by reference and no other amendments and on file with the Office of the Secretary of State. Test results shall be reported directly to the Department.

Historical Note
Adopted effective October 19, 1993 (Supp. 93-4).

R9-6-411. Repealed

Historical Note
Amended effective February 25, 1976 (Supp. 76-1). Repealed effective October 19, 1993 (Supp. 93-4).

R9-6-412. Repealed

Historical Note
Correction, adding Historical Note: Amended effective February 25, 1976 (Supp. 87-1). Repealed effective October 19, 1993 (Supp. 93-4).

R9-6-413. Repealed

Historical Note
Amended effective February 25, 1976 (Supp. 76-1). Amended effective June 4, 1980 (Supp. 80-3). Amended effective January 28, 1987 (Supp. 87-1). Repealed effective October 19, 1993 (Supp. 93-4).

R9-6-414. Repealed

Historical Note
Amended effective February 25, 1976 (Supp. 76-1). Repealed effective October 19, 1993 (Supp. 93-4).

R9-6-415. Repealed

Historical Note
Amended effective February 25, 1976 (Supp. 76-1). Repealed effective October 19, 1993 (Supp. 93-4).

R9-6-416. Repealed

Historical Note
Amended effective February 25, 1976 (Supp. 76-1). Repealed effective October 19, 1993 (Supp. 93-4).

R9-6-417. Repealed

Historical Note
Repealed effective October 19, 1993 (Supp. 93-4).

R9-6-418. Repealed

Historical Note
Amended effective February 25, 1976 (Supp. 76-1). Repealed effective October 19, 1993 (Supp. 93-4).

R9-6-419. Repealed

Historical Note
Repealed effective October 19, 1993 (Supp. 93-4).

R9-6-420. Reserved

R9-6-421. Reserved

R9-6-422. Reserved

R9-6-423. Reserved

R9-6-424. Reserved

R9-6-425. Reserved

R9-6-426. Reserved

R9-6-427. Reserved

R9-6-428. Reserved

R9-6-429. Reserved

R9-6-430. Reserved

R9-6-431. Repealed

Historical Note
Repealed effective October 19, 1993 (Supp. 93-4).

R9-6-432. Repealed

Historical Note
Amended effective February 25, 1976 (Supp. 76-1). Repealed effective October 19, 1993 (Supp. 93-4).

R9-6-433. Repealed

Historical Note
Repealed effective October 19, 1993 (Supp. 93-4).

ARTICLE 5. RABIES CONTROL

R9-6-501. Animals Exposed to a Known Rabid Animal

A. An animal control agency shall manage a dog or cat that has direct contact with a known or suspected rabid animal according to 1 of the following procedures:
1. Euthanize;
2. Confine in isolation for 180 days under the supervision and control of the county or municipal animal control agency and vaccinate 30 days before release:
   a. If the exposed animal was never vaccinated,
   b. If the exposed animal was vaccinated with a triennial vaccine more than 3 years before being exposed, or
   c. If the exposed animal was vaccinated with any other vaccine more than a year before being exposed;
3. Revaccinate and confine in isolation for 90 days under the supervision and control of the county or municipal animal control agency, if the animal was vaccinated less than 30 days before being exposed; or
4. Revaccinate within 7 days, confine and observe by the owner for 45 days with the approval and supervision of the county or municipal animal control agency under the following circumstances:
   a. If the animal was vaccinated with a triennial vaccine more than 30 days and less than 3 years before being exposed, or
   b. If the animal was vaccinated with any other vaccine more than 30 days and less than 1 year before being exposed.

B. The animal control agency shall immediately euthanize, an animal, except a cat, dog, or livestock, exposed to a known rabid animal.

C. The animal control agency shall handle a dog or cat exposed to a suspected rabid animal in the same manner as 1 exposed to a known rabid animal, except that confinement shall be terminated at such time as it is determined that the biting animal is not rabid. Such determination shall be a negative rabies report from the Department laboratory, or a certificate signed by a veterinarian stating that the suspected animal is no longer showing symptoms of rabies.

D. Livestock shall be handled according to Department of Agriculture rule A.A.C. R3-2-408.

Historical Note
Amended effective December 22, 1976 (Supp. 76-5). Correction, this Section shown as amended effective December 22, 1976 should read amended effective May 12, 1977 (Supp. 77-3). Corrections, Subsections (A), (B) and (C) (Supp. 77-5). Amended effective April 10, 1980 (Supp. 80-2). Former Section R9-6-116 renumbered without change as R9-6-501 effective January 28, 1987 (Supp. 87-1). Section R9-6-501 repealed, new Section adopted effective January 20, 1992 (Supp. 92-1). Former Section R9-6-501 renumbered to R9-6-701, new Section R9-6-501 renumbered from R9-6-201 and amended effective October 19, 1993 (Supp. 93-4). Amended effective April 4, 1997 (Supp. 97-2).

R9-6-502. Suspect Rabies Cases

A. The animal control agency shall confine, supervise, and control an animal, other than livestock, that shows symptoms of rabies when captured until it dies or a veterinarian determines it is no longer showing symptoms of rabies.

B. Whenever the animal control agency euthanizes a suspected rabid animal, it shall be done in such a way as to avoid damaging the brain, so rabies testing can be performed.

Historical Note
Amended effective December 22, 1976 (Supp. 76-5). Correction, this Section shown as amended effective December 22, 1976 should read amended effective May 12, 1977 (Supp. 77-3). Amended effective April 10, 1980 (Supp. 80-2). Amended as an emergency effective August 31, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-4). Emergency expired. Former R9-6-117 amended as a permanent rule by adding a new Subsection (C) and repealing the former Subsections (C), (D) and (E) effective January 21, 1983 (Supp. 83-1). Former Section R9-6-117 renumbered without change as R9-6-502 effective January 28, 1987 (Supp. 87-1). Section R9-6-502 repealed, new Section adopted effective January 20, 1992 (Supp. 92-1). Former Section R9-6-502 renumbered to R9-6-702, new Section R9-6-502 renumbered from R9-6-202 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-503. Records Submitted by Enforcement Agents

By April 30 of each year, municipal, county and other animal control agents shall file with the Department a report of activities during the preceding calendar year. The report shall consist of animal control agent activities which include the number of dogs licensed, the number of stray dogs and cats impounded and method of disposition, the number and species of wild animals disposed of, and the number of animal bites reported by species of animal.

Historical Note
Amended effective December 22, 1976 (Supp. 76-5). Correction, this Section shown as amended effective December 22, 1976 should read amended effective May 12, 1977 (Supp. 77-3). Amended effective April 10, 1980 (Supp. 80-2). Amended as an emergency effective August 31, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-4). Emergency expired. Former R9-6-118 amended as a permanent rule by repealing Subsection (C) and renumbering Subsections (D) through (I) effective January 21, 1983 (Supp. 83-1). Former Section R9-6-118 renumbered without change as R9-6-503 effective January 28, 1987 (Supp. 87-1). Section R9-6-503 repealed, new Section adopted effective January 20, 1992 (Supp. 92-1). Former Section R9-6-503 renumbered to R9-6-703, new Section R9-6-503 renumbered from R9-6-203 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-504. Renumbered

Historical Note
Amended effective December 22, 1976 (Supp. 76-5). Correction, this Section shown as amended effective December 22, 1976 should read amended effective May 12, 1977 (Supp. 77-3). Amended effective April 10, 1980 (Supp. 80-2). Amended as an emergency effective August 31, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-4). Emergency expired. Former R9-6-119 amended as a permanent rule by repealing Subsections (A) and (B), renumbering and amending Subsections (C) through (I) effective January 21, 1983 (Supp. 83-1). Former Section R9-6-119 renumbered without change as R9-6-504 effective January 28, 1987 (Supp. 87-1). Section R9-6-504 repealed, new Section adopted effective January 20, 1992 (Supp. 92-1). Former Section R9-6-504 renumbered to R9-6-704 effective October 19, 1993 (Supp. 93-4).

R9-6-505. Renumbered

Historical Note
Adopted effective January 20, 1992 (Supp. 92-1). Former Section R9-6-505 renumbered to R9-6-705 effective October 19, 1993 (Supp. 93-4).

R9-6-506. Renumbered

Historical Note
Adopted effective January 20, 1992 (Supp. 92-1). Former Section R9-6-506 renumbered to R9-6-706 effective October 19, 1993 (Supp. 93-4).

Table 1. Renumbered

Historical Note
Adopted effective January 20, 1992 (Supp. 92-1). Former Section R9-6-506, Table 1 renumbered to R9-6-706 Table 1 effective October 19, 1993 (Supp. 93-4).

Table 2. Renumbered

Historical Note
Adopted effective January 20, 1992 (Supp. 92-1). Former Section R9-6-506, Table 2 renumbered to R9-6-706, Table 2 effective October 19, 1993 (Supp. 93-4).

ARTICLE 6. TUBERCULOSIS CONTROL

R9-6-601. Reports of Disease and Infection; Tuberculosis Registry

A. A person shall report a case of tuberculosis or a tuberculosis infection in a child under age six in accordance with R9-6-202.

B. The local health agency shall provide the following information to the Department:

1. Medical information regarding all individuals with diagnosed tuberculosis disease in its jurisdiction, regardless of the supervising agency.
2. Medical information regarding individuals suspected of having tuberculosis disease, those exposed to communicable tuberculosis disease, those with tuberculosis infection, and other individuals receiving tuberculosis treatment or services through the local health agency.

C. A register of persons having tuberculosis shall be maintained by the State Tuberculosis Control Officer.

Historical Note

Adopted effective January 28, 1987 (Supp. 87-1). Former Section R9-6-601 renumbered to R9-6-201, new Section R9-6-601 adopted effective October 19, 1993 (Supp. 93-4).

R9-6-602. Issuance and Enforcement of an Order for Isolation and Quarantine

A. The State Tuberculosis Control Officer, or a deputized qualified employee of the Department or other governmental health agency, may issue or revoke an Order of Isolation and Quarantine.

B. Orders of Isolation and Quarantine pursuant to A.R.S. § 36-714 shall be issued for a period not to exceed 30 days.

C. All persons deputized to issue an Order of Isolation and Quarantine shall send written notice to the State Tuberculosis Control Officer of the issuance of an Order of Isolation and Quarantine within five working days of such issuance. The notice shall include the description of the person quarantined, the basis upon which it is believed or suspected that such person is afflicted with contagious tuberculosis disease and shall include a copy of the issued Order of Isolation and Quarantine.

D. The local health agency shall be responsible for serving Orders of Isolation and Quarantine.

Historical Note

Adopted effective January 28, 1987 (Supp. 87-1). Former Section R9-6-602 renumbered to R9-6-202, new Section R9-6-601 adopted effective October 19, 1993 (Supp. 93-4).

R9-6-603. Removal of Persons to Another State or Country

A. When a case of communicable tuberculosis disease has financial support from out-of-state, the State Tuberculosis Control Officer, with written assurance of such support, shall furnish the patient with travel expenses and subsistence sufficient for the case to reach such support. The State Tuberculosis Control Officer shall ensure this transfer promotes the welfare of both the care and the state.

B. The State Tuberculosis Control Officer shall designate the method of transportation that best assures the safety of the patient and the public.

Historical Note

Adopted effective January 28, 1987 (Supp. 87-1). Amended effective September 14, 1990 (Supp. 90-3). Repealed effective October 19, 1993 (Supp. 93-4), new Section R9-6-603 adopted effective October 19, 1993 (Supp. 93-4).

R9-6-604. Repealed

Historical Note

Adopted effective January 28, 1987 (Supp. 87-1). Amended effective September 14, 1990 (Supp. 90-3). Repealed effective October 19, 1993 (Supp. 93-4).

R9-6-605. Repealed

Historical Note

Adopted effective January 28, 1987 (Supp. 87-1). Amended effective September 14, 1990 (Supp. 90-3). Repealed effective October 19, 1993 (Supp. 93-4).

R9-6-606. Emergency Expired

Historical Note

Adopted as an emergency effective October 12, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-4). Emergency expired. Emergency rule readopted without change effective February 22, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-1). Emergency expired. Emergency rule readopted with changes effective July 3, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-3). Emergency expired.

ARTICLE 7. VACCINE PREVENTABLE DISEASES

R9-6-701. Required Immunizations for Child Care or School Entry

A. Except as permitted in R9-6-705:

1. Before entry in a school, or no later than 15 days following entry in a child care, a child, an individual more than 18 years of age, or an emancipated person shall be immunized against each of the following diseases:
   a. Diphtheria,
   b. Tetanus,
   c. Hepatitis B,
   d. Pertussis,
   e. Poliomyelitis,
   f. Measles (rubeola),
   g. Mumps,
   h. Rubella (German Measles), and
   i. *Haemophilus influenzae* type b.
2. A child aged 2 through 5 years old in child care in Maricopa County shall be immunized against the hepatitis A virus.

B. A child, an individual more than 18 years of age, or an emancipated person shall be immunized in accordance with the schedule in Tables 1 or 2. The Department or a school administrator may exempt a child, an individual more than 18 years of age, or an emancipated person from immunizations as authorized by A.R.S. § 15-873 or A.R.S. § 36-883(C).

Historical Note

Former Section R9-6-115, Paragraph (47), renumbered and amended as R9-6-701 effective January 28, 1987 (Supp. 87-1). Amended effective September 14, 1990 (Supp. 90-3). Former Section R9-6-701 renumbered to Section R9-6-328, new Section R9-6-701 renumbered from R9-6-501 and amended effective October 19, 1993 (Supp. 93-4). Amended effective April 4, 1997 (Supp. 97-2). Amended by final rulemaking at 5 A.A.R. 496, effective January 19, 1999 (Supp. 99-1).

R9-6-702. Responsibilities of Physicians and Local Health Agencies for Administering Immunizations

A. Upon request of the responsible person, each county health department shall provide for the immunization of any child against the diseases listed in R9-6-701(A).

B. The dosage and route of administration of each vaccine or immunizing agent shall be in accordance with the manufacturer's recommendations.

C. Prior to the immunization of any child, the physician, county health officer, or other authorized representative, shall provide the responsible person with an information statement which includes the following:

1. A description of the disease,
2. A description of the vaccine,
3. A statement of the risks of the disease and the risks and benefits of immunization, and
4. Contraindications for administration of the vaccine.

D. Prior to the administration of immunization to any child, the physician, county health officer, or person authorized to administer vaccines, shall obtain a signed statement confirming that the responsible person:

1. Has read and understands the information furnished about the risks and benefits of the vaccine or immunizing agent to be administered,
2. Has had the opportunity to ask questions, and
3. Requests that the designated vaccines or immunizing agents be administered to the child.

E. Following the administration of vaccines or immunizing agents to any child, the physician or authorized representative of a local health agency authorized to perform the immunizations shall furnish written information to the responsible person regarding:
1. The vaccines or immunizing agents given,
2. The reactions that might be expected, and
3. The course of action if an unusually severe reaction occurs. If the child receives the vaccine or immunizing agent at school, the information shall be given to the child with instructions to give it to the responsible person.

F. The physician or authorized representative of the local health agency performing the immunization shall provide a written record to the person immunized or to the responsible person. This record shall conform to the standards of documentary proof pursuant to R9-6-703.

Historical Note
Former Section R9-6-115, Paragraph (1), renumbered and amended as R9-6-702 effective January 28, 1987 (Supp. 87-1). Former Section R9-6-702 renumbered to Section R9-6-302, new Section R9-6-702 renumbered from R9-6-502 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-703. Standards for Documentary Proof

A. Proof of immunity to the diseases listed in R9-6-701(A) shall be documented by the following:
1. An immunization record that contains:
   a. Name of the person;
   b. Birth date;
   c. Type of vaccine administered;
   d. Month and year of each immunization, except for MMR, for which month, day, and year is required; and
   e. Name of the physician or authorized representative of a health agency administering the vaccine; or
2. Laboratory evidence of immunity as defined in A.R.S. § 36-671(8).

B. A physician or authorized representative of a health agency shall sign an immunization record or statement of immunity.

Historical Note
Former Section R9-6-115, Paragraph (2), renumbered and amended as R9-6-703 effective January 28, 1987 (Supp. 87-1). Former Section R9-6-703 renumbered to Section R9-6-303, new Section R9-6-703 renumbered from R9-6-503 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-704. Responsibilities of Schools

A. As of January 1, 1992, a school shall forbid attendance of any pupil not meeting the requirements for immunization or exemption from immunization and shall suspend such pupils pursuant to A.R.S. § 15-843.

B. The admitting official shall determine the pupil to be in compliance with the requirements of this Article when:
1. The pupil's immunization record complies with the documentary proof required pursuant to R9-6-703, and the pupil has received or is in the process of receiving all required age-specific vaccine doses according to Table 1; or
2. An exemption from immunization is submitted in accordance with the requirements set forth in R9-6-705.

C. When the pupil's immunization record is not available at the time of enrollment, a school shall provide the responsible person with the following:
1. Notification of the lack of compliance with the immunization requirements;
2. Written notification which specifies when the required doses shall be completed, specifies the availability of exemptions to immunization, and refers the pupil to a physician or local health agency for review of the pupil's immunization history and provision of immunizations as needed; and
3. Notification that the pupil is suspended until an acceptable immunization record which meets the standards of documentary proof is presented to the school.

D. When immunization records are presented which do not comply with the standards for documentary proof, a school shall:
1. Notify the responsible person of the lack of compliance with the immunization requirements; and
2. Obtain a review and verification of the pupil's immunization record by or in consultation with a certified school nurse, a public health nurse, a licensed physician, or authorized representative of a local health agency.

E. If the admitting official is unable to verify the accuracy of the pupil's immunization record pursuant to subsection (D), a school shall provide to the responsible person:
1. A written referral to a physician or local health agency for further review of the pupil's immunization history and provision of immunizations as needed, and
2. Notification that the pupil is suspended until an immunization record that meets the standards of documentary proof is presented to the school.

F. All schools shall maintain a current list of pupils without evidence of immunization or immunity to the diseases listed in R9-6-701(A). The list shall contain the names of all pupils with incomplete immunization histories or exemptions for personal or medical reasons where evidence of immunity has not been provided.

G. A public or private school shall forbid attendance by any pupils lacking proof of immunization or immunity against any of the diseases listed in R9-6-701(A) during period of outbreaks of those diseases for which immunity is lacking. The Department or local health agency shall announce an outbreak of disease and shall declare the length of the period of communicability.

Historical Note
Adopted effective January 28, 1987 (Supp. 87-1). Former Section R9-6-704 renumbered to Section R9-6-304, new Section R9-6-704 renumbered from R9-6-504 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-705. Exemptions to Immunizations

A. A pupil who has reached a fifth birthday shall be exempt from the Hib immunization requirement.

B. A pupil who has reached a seventh birthday shall be exempt from the pertussis immunization requirement.

C. A pupil with laboratory evidence of immunity shall not be subject to immunization against that disease as a condition for attending a school, provided that such evidence is submitted to the school.

D. If a medical exemption is granted in accordance with A.R.S. § 15-873(A)(2), a physician shall define the exemption as either permanent or temporary.
1. A permanent medical exemption may be provided for one or more vaccines.

2. A temporary medical exemption shall specify the date of its termination. A school shall allow a pupil with a temporary medical exemption to attend school on the condition that the required immunizations are obtained at the termination of the exemption. The school shall notify the responsible person of the date by which the pupil shall complete all required immunizations.

E. A school shall record an exemption granted in accordance with A.R.S. § 15-873 on the school immunization record in the pupil's permanent file.

Historical Note
Adopted effective January 28, 1987 (Supp. 87-1). Former Section R9-6-705 renumbered to Section R9-6-305, new Section R9-6-705 renumbered from R9-6-505 and amended effective October 19, 1993 (Supp. 93-4).

R9-6-706. Required Reports

A. By November 30 of each year, the administrator of each school district and private school shall submit to the Department or local health agency an immunization status report. The report shall contain the following information:
1. Enrollment as of October 15 of that year;
2. The number of pupils with documentary proof of immunization status, specifying the number who:
   a. Have received all immunizations required for their age;
   b. Are medically exempt, specifying on a permanent basis or temporary basis;
   c. Are exempt for personal beliefs; and
   d. Have submitted laboratory evidence of immunity;
3. The number of new entrants without documentary proof of immunization status, specifying the number with incomplete immunizations; and
4. The number of licensed child care centers, schools with pre-kindergarten, kindergarten, or if no kindergarten, 1st grade pupils, specifying the number of pupils admitted and the number of doses received per pupil of diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps, rubella, and hepatitis B vaccines. The number of doses of Hib vaccine shall also be reported for those students under age 5.

B. The Department or local health agency shall require additional reports as needed which include immunization information about pupils in all grades during an outbreak or potential outbreak as determined by the Department or local health agency.

C. Each administrator of a school whose nurses are authorized to administer vaccines or immunizing agents shall submit monthly reports to the county health department which shall include the number of doses of each vaccine or immunizing agent administered, by specified age group, in each school under the administrator's jurisdiction. Reports are due by the 5th day of the following month.

D. Each county health officer shall submit monthly reports to the Department which shall include the number of doses of each vaccine or immunizing agent administered, by specified age group, in each school district and at county health department clinics. Reports are due by the last day of the following month.

E. The school shall maintain an immunization record for each child attending preschool or a child care program operated at a public school. A record shall include the following information:
1. Name of the pupil;
2. Date of birth; and
3. The month and year in which all vaccines were received, except for measles, mumps, and rubella, for which the day, month, and year is required.

F. By November 30 of each year each operator of a licensed child care center, public school-based child care program, or preschool shall submit a report to the county health department which shall include the following information:
1. The number of pupils in regular attendance at the public school-based child care center or preschool during the month of October. Pupils in regular attendance are those who are enrolled for 11 or more days during that 31-day period.
2. The number of pupils for whom immunization records are on file.
3. The number of pupils who have received immunizations against diphtheria, tetanus, pertussis, poliomyelitis, measles (rubeola), rubella (German measles), mumps, Hib, and hepatitis B, and the number of doses of each vaccine or immunizing agent that have been received.

G. By January 1 of each year, each county health officer shall forward to the Department copies of all reports received pursuant to subsections (A) and (F).

H. A health care professional licensed under A.R.S. Title 32 shall report all immunizations administered to children to the Department in accordance with A.R.S. § 36-135.

I. Information submitted in accordance with A.R.S. § 36-135(C) shall be furnished as follows:
1. If using the mail or fax, only forms supplied by the Department shall be used, which must be fully completed before submission.
2. If using the telephone, all required information must be reported during regular business hours to a telephone number provided by the Department for this purpose.
3. If using the computer, an enrollment process must be completed with ASIIS to certify that the computer system meets the technical specifications defined by ASIIS.
   a. Computer reporting may be performed electronically via a modem connection to the ASIIS Gateway or by submission to the Department of a 3 1/2" diskette with the required information.
   b. Any computer reporting from systems other than those provided by ASIIS must provide all the required information in an American Standard Character Information Interchange delimited format.

J. A physician or an authorized designee, shall submit a written report to the Department of all patients who receive post-exposure rabies prophylaxis. The report shall include:
1. Name, age, address, and telephone number of the person exposed;
2. Date of report;
3. Reporting institution or physician;
4. Date of exposure;
5. Body part exposed;
6. Type of exposure: Bite or saliva contact (non-bite);
7. Species of animal;
8. Animal disposition: quarantined, euthanized, died, unable to locate;
9. Animal rabies test results if any: positive or negative;
10. Treatment regimen; and
11. Date treatment was initiated.

Historical Note
Former Section R9-6-115, Paragraph (3), renumbered and amended as R9-6-706 effective January 28, 1987 (Supp. 87-1). Former Section R9-6-706 renumbered to Section R9-6-306, new Section R9-6-706 renumbered from R9-6-506 and amended effective October 19, 1993 (Supp. 93-4). Amended effective April 4, 1997 (Supp. 97-2).

R9-6-707. Release of Immunization Information

In addition to those persons identified in A.R.S. § 36-135(D) who have access to immunization information, and according to the limitations defined in subsections (E) and (H), the Department may also release such information to the following:

1. Authorized representatives of state or local health departments for the control, investigation, analysis or follow-up of disease;
2. A child care operator who has registered with ASIIS to determine the immunization status of a child in the care of the operator.

Historical Note

Adopted effective April 4, 1997 (Supp. 97-4).

Table 1. Immunization Requirements for Child Care or School Entry

Age at Entry	Number of Doses Vaccine Required	Special Notes
<2 months	1 Hep B	(See Note [1])
2 through 3 months	1 DTP, DTaP or DT 1 OPV or IPV 1 Hib 1 Hep B	 (See Note [1])
4 through 5 months	2 DTP, DTaP or DT 2 OPV or IPV 2 Hib 2 Hep B	 (See Note [1])
6 through 11 months	3 DTP, DTaP or DT 2 OPV or IPV 3 Hib 3 Hep B	 (See Note [2] for a child 7 months through 59 months of age.) (See Note [1])
12 through 14 months	3 DTP, DTaP or DT 3 OPV or IPV 1-4 Hib 1 MMR 3 Hep B	 (See Note [2]) (See Note [3]) (See Note [1])
15 through 59 months	4 DTP, DTaP or DT 3 OPV or IPV 1-4 Hib 1-2 MMR 3 Hep B	 (See Note [2]) (See Note [3]) (See Note [1])
2 through 5 years (Only required for Maricopa County child care)	2 Hep A	(See Note [4])
4 through 6 years (School entry)	4 DTP, DTaP or DT 3 OPV or IPV 2 MMR 3 Hep B	A child shall receive a 5th dose if the 4th dose was received before the 4th birthday. (see Note[5]) (See Note [3]) A child entering child care or kindergarten shall receive a 2nd dose 1 month or more after the date of the 1st dose. A child initially entering school at the 1st grade level who has not already received a 2nd dose shall receive a 2nd dose 1 month or more after the date of the 1st dose. (See Note [1]) A child entering child care or kindergarten shall receive the Hep B series. A child initially entering school at the 1st grade level who has not already received the Hep B series shall receive the Hep B series.

7 years or older	4 DTP, DTaP or any combination of DTP /DT/Td	A child shall receive a 4th dose of Td before school entry if the 3rd dose of diphtheria-tetanus containing vaccine was received before the 4th birthday. A child or an individual more than 18 years of age shall receive a Td dose if 10 years or more have passed since the date of the last dose.
	3 OPV or IPV	(see Note [5])
	1 MMR	(See Note [3])
	3 Hep B	(See Note[1]) A child entering school at the kindergarten level shall receive the Hep B series. A child initially entering school at the 1st grade level who has not already received the Hep B series shall receive the Hep B series.

[1] A child shall receive the 1st dose of Hep B before kindergarten or 1st grade entry, or no later than 15 days following child care entry. A child shall receive the 2nd dose of Hep B 4 weeks or more after the date of the 1st dose. A child who is 6 months of age or older shall receive the 3rd dose 2-5 months after the date of the 2nd dose and 4 months or more after the date of the 1st dose.

[2] A child 0 through 2 months old shall receive the 3 dose Hib series when the child is 2, 4, and 6 months old, with a 4th dose when the child is 12-15 months old. See Table 2, footnote 2, for a child who receives the 1st dose of Hib at 3 months of age or older.

[3] A child who is 12 months of age or older, or an individual more than 18 years of age, shall receive measles, mumps, and rubella vaccines as individual antigens or as combined MMR vaccine. A child or an individual more than 18 years of age shall receive the 1st dose of MMR before school entry, or no later than 15 days following child care entry. A child aged 4 through 6 years old who is entering child care, kindergarten or 1st grade shall receive a 2nd dose 1 month or more after the date of the 1st dose.

[4] A child 2 through 5 years old shall receive the 1st dose of hepatitis A vaccine no later than 15 days following child care entry in Maricopa County, in accordance with A.A.C. R9-5-305(C). A child shall receive a 2nd dose 6 months following the date of the 1st dose. If 6 months or more have passed since the date of the 1st dose, a child shall receive the 2nd dose no later than 15 days after entry. These rules apply to any child 2 through 5 years old who is entering or has already entered child care in Maricopa County on the effective date of these rules.

[5] A child shall receive a 4th dose of OPV or IPV for school entry if the 3rd dose was received before the 4th birthday. OPV or IPV is not required for individuals more than 18 years of age for school entry.

Historical Note

Adopted effective January 20, 1992 (Supp. 92-1). Article 7, Table 1 renumbered from Article 5, Table 1 and amended effective October 19, 1993 (Supp. 93-4). Amended effective April 4, 1997 (Supp. 97-2). Amended by final rulemaking at 5 A.A.R. 496, effective January 19, 1999 (Supp. 99-1).

Table 2. Catch-Up Immunization Schedule for Child Care or School Entry

Vaccine	Dose	Time Intervals
1. DTP - Diphtheria, Tetanus and Pertussis		
a. For a Child Less Than 7 Years of Age: DTP or any combination of DTP, DTaP and DT	1st	A child shall receive the 1st dose before school entry, or no later than 15 days following child care entry.
	2nd	If 4 weeks or more have passed since the date of the 1st dose, a child shall receive the 2nd dose before school entry, or no later than 15 days following child care entry.
	3rd	If 4 weeks or more have passed since the date of the 2nd dose, a child shall receive the 3rd dose before school entry, or no later than 15 days following child care entry.
	4th	If 6 months or more have passed since the date of the 3rd dose, a child shall receive the 4th dose before school entry, or no later than 15 days following child care entry.
	5th or more	If a child received the 4th dose before the child's 4th birthday, the child shall receive a 5th dose before school entry, or no later than 15 days following child care entry. If a child received the 4th dose after the child's 4th birthday, the child shall receive a dose of Td 10 years after the date of the 4th dose.
b. For a Child Aged 7 Years and Older, or An Individual More Than 18 Years of Age: Td - Tetanus Diphtheria (Pertussis not required)	1st	Before school entry.
	2nd	If 4 weeks or more have passed since the date of the 1st dose, a child or an individual more than 18 years of age shall receive the 2nd dose before school entry.
	3rd	If 6 months or more have passed since the date of the 2nd dose, a child or an individual more than 18 years of age shall receive the 3rd dose before school entry. A child or individual more than 18 years of age shall receive a dose of Td 10 years after the date of the 3rd dose.
2. OPV or IPV - Polio (See Note [1] below.)	1st	A child shall receive the 1st dose before school entry, or no later than 15 days following child care entry.
	2nd	If 4 weeks or more have passed since the date of the 1st dose, a child shall receive the 2nd dose before school entry, or no later than 15 days following child care entry.
	3rd	For a child who has received 2 doses of IPV, OPV, or 1 dose of each, if 4 weeks or more have passed since the date of the 2nd dose, the child shall receive the 3rd dose of IPV or OPV before school entry, or no later than 15 days following child care entry.
3. MMR - Measles, Mumps, Rubella	1st	A child who is 12 months of age or older, or an individual more than 18 years of age, shall receive the 1st dose before school entry, or no later than 15 days following child care entry.
	2nd	If 1 month or more have passed since the date of the 1st dose, a child who is 4 years of age or older shall receive the 2nd dose before kindergarten entry, or no later than 15 days following child care entry. A child initially entering school at the 1st grade level who has not already received a 2nd dose shall receive a 2nd dose.
4. Hib - *Haemophilus influenzae* type b (See Note [2] below.) (Not required for individuals aged 5 years and older.)	1	A child who is less than 5 years of age shall receive the vaccine before school entry, or no later than 15 days following child care entry.

5. Hep B - Hepatitis B Kindergarten and 1st grade only	1st	A child shall receive the 1st dose before kindergarten entry, or no later than 15 days following child care entry. A child initially entering school at the 1st grade level who has not already had the Hep B series shall also receive the Hep B series.
	2nd	If 4 weeks or more have passed since the date of the 1st dose, a child shall receive the 2nd dose before kindergarten or 1st grade entry, or no later than 15 days following child care entry
	3rd	If 2 months or more have passed since the date of the 2nd dose, and 4 months or more have passed since the date of the 1st dose, a child shall receive the 3rd dose, before kindergarten or 1st grade entry, or no later than 15 days following child care entry
6. Hep A - Hepatitis A Only required for Maricopa County child care	1st	A child who is 24 through 71 months of age shall receive the 1st dose no later than 15 days following child care entry.
	2nd	If 6 months or more have passed since the date of the 1st dose, a child shall receive the 2nd dose no later than 15 days following child care entry.

[1] A child shall receive a 4th dose of OPV or IPV if the 3rd dose was received before the 4th birthday. OPV or IPV is not required for individuals more than 18 years of age for school entry.

[2] A child 0 through 2 months old shall receive the 3 dose Hib series when the child is 2, 4, and 6 months old with a 4th dose when the child is 12-15 months old. A child 3 through 6 months old who is starting the Hib series shall receive 4 doses: 1 dose before entry, the 2nd dose 2 months after the date of the 1st dose, the 3rd dose 2 months after the date of the 2nd dose, and a 4th dose when 12-15 months old. A child 7 through 11 months old who is starting the Hib series shall receive 3 doses: 1 dose before entry, the 2nd dose 2 months after the date of the 1st dose, and a 3rd dose when 12-15 months old. A child 12 through 14 months old who is starting the Hib series shall receive 2 doses: 1 dose before entry, followed by a 2nd dose 2 months or more after the date of the 1st dose, but not before age 15 months. A child 15 through 59 months old who is starting the Hib series shall receive a single dose before entry and does not require another dose.

Historical Note

Adopted effective January 20, 1992 (Supp. 92-1). Article 7, Table 2 renumbered from Article 5, Table 2 and amended effective October 19, 1993 (Supp. 93-4). Amended effective April 4, 1997 (Supp. 97-2). Amended by final rulemaking at 5 A.A.R. 496, effective January 19, 1999 (Supp. 99-1).

R9-6-707. Renumbered

Historical Note

Former Section R9-6-115, Paragraph (5), renumbered and amended as R9-6-707 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-307 effective October 19, 1993 (Supp. 93-4).

R9-6-708. Renumbered

Historical Note

Adopted effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-309 effective October 19, 1993 (Supp. 93-4).

R9-6-709. Renumbered

Historical Note

Former Section R9-6-115, Paragraph (6), renumbered and amended as R9-6-709 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-310 effective October 19, 1993 (Supp. 93-4).

R9-6-710. Renumbered

Historical Note

Former Section R9-115, Paragraph (7), renumbered and amended as R9-6-710 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-311 effective October 19, 1993 (Supp. 93-4).

R9-6-711. Renumbered

Historical Note

Former Section R9-6-115, Paragraph (8), renumbered and amended as R9-6-711 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-313 effective October 19, 1993 (Supp. 93-4).

R9-6-712. Renumbered

Historical Note

Adopted effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-315 effective October 19, 1993 (Supp. 93-4).

R9-6-713. Renumbered

Historical Note

Former Section R9-6-115, Paragraph (9), renumbered and amended as R9-6-713 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-316 effective October 19, 1993 (Supp. 93-4).

R9-6-714. Renumbered

Historical Note

Former Section R9-6-115, Paragraph (10), renumbered and amended as R9-6-714 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-317 effective October 19, 1993 (Supp. 93-4).

R9-6-715. Renumbered

Historical Note

Former Section R9-6-115, Paragraph (11), renumbered and amended as R9-6-715 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-319 effective October 19, 1993 (Supp. 93-4).

R9-6-716. Renumbered

Historical Note
Adopted effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-320 effective October 19, 1993 (Supp. 93-4).

R9-6-717. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (12), renumbered and amended as R9-6-717 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-321 effective October 19, 1993 (Supp. 93-4).

R9-6-718. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (13), renumbered and amended as R9-6-718 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-322 effective October 19, 1993 (Supp. 93-4).

R9-6-719. Renumbered

Historical Note
Adopted effective January 28, 1987 (Supp. 87-1) Renumbered to Section R9-6-323 effective October 19, 1993 (Supp. 93-4).

R9-6-720. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (14), renumbered and amended as R9-6-720 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-324 effective October 19, 1993 (Supp. 93-4).

R9-6-721. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (15), renumbered and amended as R9-6-721 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-325 effective October 19, 1993 (Supp. 93-4).

R9-6-722. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (18), renumbered and amended as R9-6-722 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-327 effective October 19, 1993 (Supp. 93-4).

R9-6-723. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (16), renumbered and amended as R9-6-723 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-330 effective October 19, 1993 (Supp. 93-4).

R9-6-724. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (17), renumbered and amended as R9-6-724 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-331 effective October 19, 1993 (Supp. 93-4).

R9-6-725. Renumbered

Historical Note
Adopted effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-332 effective October 19, 1993 (Supp. 93-4).

R9-6-726. Renumbered

Historical Note
Adopted effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-333 effective October 19, 1993 (Supp. 93-4).

R9-6-727. Renumbered

Historical Note
Adopted effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-334 effective October 19, 1993 (Supp. 93-4).

R9-6-728. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (19), renumbered and amended as R9-6-728 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-335 effective October 19, 1993 (Supp. 93-4).

R9-6-729. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (20), renumbered and amended as R9-6-729 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-336 effective October 19, 1993 (Supp. 93-4).

R9-6-730. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (21), renumbered and amended as R9-6-730 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-337 effective October 19, 1993 (Supp. 93-4).

R9-6-731. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (22), renumbered and amended as R9-6-731 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-338 effective October 19, 1993 (Supp. 93-4).

R9-6-732. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (23), renumbered and amended as R9-6-732 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-339 effective October 19, 1993 (Supp. 93-4).

R9-6-733. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (45), renumbered and amended as R9-6-733 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-340 effective October 19, 1993 (Supp. 93-4).

R9-6-734. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (24), renumbered and amended as R9-6-734 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-341 effective October 19, 1993 (Supp. 93-4).

R9-6-735. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (25), renumbered and amended as R9-6-735 effective January 28, 1987

(Supp. 87-1). Renumbered to Section R9-6-342 effective October 19, 1993 (Supp. 93-4).

R9-6-736. Renumbered

Historical Note
Former R9-6-115, Paragraph (26), renumbered and amended as R9-6-736 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-343 effective October 19, 1993 (Supp. 93-4).

R9-6-737. Renumbered

Historical Note
Adopted effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-344 effective October 19, 1993 (Supp. 93-4).

R9-6-738. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (27), renumbered and amended as R9-6-738 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-345 effective October 19, 1993 (Supp. 93-4).

R9-6-739. Renumbered

Historical Note
Adopted effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-346 effective October 19, 1993 (Supp. 93-4).

R9-6-740. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (28), renumbered and amended as R9-6-740 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-347 effective October 19, 1993 (Supp. 93-4).

R9-6-741. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (29), renumbered and amended as R9-6-741 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-348 effective October 19, 1993 (Supp. 93-4).

R9-6-742. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (30), renumbered and amended as R9-6-742 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-349 effective October 19, 1993 (Supp. 93-4).

R9-6-743. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (31), renumbered and amended as R9-6-743 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-350 effective October 19, 1993 (Supp. 93-4).

R9-6-744. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (32), renumbered and amended as R9-6-744 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-351 effective October 19, 1993 (Supp. 93-4).

R9-6-745. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (33), renumbered and amended as R9-6-745 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-352 effective October 19, 1993 (Supp. 93-4).

R9-6-746. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (34.) renumbered and amended as R9-6-746 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-353 effective October 19, 1993 (Supp. 93-4).

R9-6-747. Repealed

Historical Note
Former Section R9-6-115, Paragraph (35), renumbered and amended as R9-6-747 effective January 28, 1987 (Supp. 87-1). Repealed effective October 19, 1993 (Supp. 93-4).

R9-6-748. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (36), renumbered and amended as R9-6-748 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-354 effective October 19, 1993 (Supp. 93-4).

R9-6-749. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (37), renumbered and amended as R9-6-749 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-355 effective October 19, 1993 (Supp. 93-4).

R9-6-750. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (38), renumbered and amended as R9-6-750 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-356 effective October 19, 1993 (Supp. 93-4).

R9-6-751. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (39), renumbered and amended as R9-6-751 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-358 effective October 19, 1993 (Supp. 93-4).

R9-6-752. Renumbered

Historical Note
Adopted effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-359 effective October 19, 1993 (Supp. 93-4).

R9-6-753. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (40), renumbered and amended as R9-6-753 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-360 effective October 19, 1993 (Supp. 93-4).

R9-6-754. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (41), renumbered and amended as R9-6-754 effective January 28, 1987

(Supp. 87-1). Renumbered to Section R9-6-361 effective October 19, 1993 (Supp. 93-4).

R9-6-755. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (42), renumbered and amended as R9-6-755 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-362 effective October 19, 1993 (Supp. 93-4).

R9-6-756. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (43), renumbered and amended as R9-6-756 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-363 effective October 19, 1993 (Supp. 93-4).

R9-6-757. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (44), renumbered and amended as R9-6-757 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-364 effective October 19, 1993 (Supp. 93-4).

R9-6-758. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (4), renumbered and amended as R9-6-758 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-365 effective October 19, 1993 (Supp. 93-4).

R9-6-759. Renumbered

Historical Note
Former Section R9-6-115, Paragraph (46), renumbered and amended as R9-6-759 effective January 28, 1987 (Supp. 87-1). Renumbered to Section R9-6-366 effective October 19, 1993 (Supp. 93-4).

ARTICLE 8. RENUMBERED

R9-6-801. Renumbered

Historical Note
Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Amended and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted without change as an emergency effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Adopted without change as a permanent rule effective May 22, 1989. Amended as an emergency effective June 26, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Emergency amendment readopted without change effective October 17, 1989 (Supp. 89-4). Amended effective September 19, 1990 (Supp. 90-3). Renumbered to R9-6-401 effective October 19, 1993 (Supp. 93-4).

R9-6-802. Renumbered

Historical Note
Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Amended and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted without change as an emergency effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Adopted without change as a permanent rule effective May 22, 1989 (Supp. 89-2). Amended effective September 19, 1990 (Supp. 90-3). Amended as an emergency effective August 8, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency expired. Emergency amendments re-adopted without change effective November 19, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-4). Emergency expired. Emergency amendments re-adopted without change effective February 28, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-1). Emergency expired. Renumbered to R9-6-402 effective October 19, 1993 (Supp. 93-4).

R9-6-803. Renumbered

Historical Note
Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Amended and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted without change as an emergency effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Amended Subsection (B) and adopted as a permanent rule effective May 22, 1989 (Supp. 89-2). Amended as an emergency effective August 8, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency expired. Emergency amendments re-adopted without change effective November 19, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-4). Emergency expired. Emergency amendments re-adopted without change effective February 28, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-1). Emergency expired. Renumbered to R9-6-403 effective October 19, 1993 (Supp. 93-4).

R9-6-804. Renumbered

Historical Note
Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Amended and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted as an emergency and Subsection (A) corrected effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Amended Subsection (B) and adopted as a permanent rule effective May 22, 1989 (Supp. 89-2). Renumbered to R9-6-404 effective October 19, 1993 (Supp. 93-4).

R9-6-805. Renumbered

Historical Note

Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Amended and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted as an emergency and Subsection (B), Paragraph (2) corrected effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Adopted without change as a permanent rule effective May 22, 1989 (Supp. 89-2). Renumbered to R9-6-405 effective October 19, 1993 (Supp. 93-4).

R9-6-806. Renumbered

Historical Note

Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Amended and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted without change as an emergency effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Adopted without change as a permanent rule effective May 22, 1989 (Supp. 89-2). Amended effective September 19, 1990 (Supp. 90-3). Renumbered to R9-6-406 effective October 19, 1993 (Supp. 93-4).

R9-6-807. Renumbered

Historical Note

Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Emergency not renewed. Former Section R9-6-808 renumbered as Section R9-6-807, amended, and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted as an emergency and Subsection (C) corrected effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Adopted without change as a permanent rule effective May 22, 1989 (Supp. 89-2). Renumbered to R9-6-407 effective October 19, 1993 (Supp. 93-4).

R9-6-808. Renumbered

Historical Note

Adopted as an emergency effective January 12, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-1). Emergency expired. Readopted without change as an emergency effective May 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Former Section R9-6-809 renumbered as Section R9-6-808, amended and readopted as an emergency effective August 8, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Readopted without change as an emergency effective November 16, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Adopted without change as a permanent rule effective May 22, 1989 (Supp. 89-2). Renumbered to R9-6-408 effective October 19, 1993 (Supp. 93-4).

TITLE 9. HEALTH SERVICES

CHAPTER 7. DEPARTMENT OF HEALTH SERVICES CHILDREN'S REHABILITATIVE SERVICES

(Authority: A.R.S. §§ 36-136(F) and 36-261(3))

Editor's Note: Articles in this Chapter were adopted under an exemption from the Administrative Procedure Act under Laws 1991, Ch, 149 § 4, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998. When these rules were adopted the APA in effect in 1992 prohibited the Secretary of State's office from publishing these exempt rules in the Administrative Code. Exemption from A.R.S. Title 41, Chapter 6 means that the Department of Health Services did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council; the Department was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is being printed on blue paper (Supp. 98-2).

ARTICLE 1. DEFINITIONS

Article 1, consisting of Sections R9-7-101 through R9-7-110, repealed; new Article 1, consisting of Section R9-7-101 adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

New Article 1 consisting of Sections R9-7-101 through R9-7-110 adopted effective August 9, 1989.

Former Article 1 consisting of Sections R9-7-101 through R9-7-121 repealed effective August 9, 1989.

Section
R9-7-101. Definitions

ARTICLE 2. MEDICAL STAFF

Article 2, consisting of Sections R9-7-201 through R9-7-210 adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

Former Article 2, consisting of Sections R9-7-201 through R9-7-204, repealed effective August 9, 1989.

Section
R9-7-201. Provider Services; Participation
R9-7-202. Application for Rostering
R9-7-203. Rostering Procedures; Exemptions
R9-7-204. Terms and Conditions of Participation for Physicians and Dental Providers
R9-7-205. Medical Executive Committees
R9-7-206. Medical Staff Assignments
R9-7-207. Active Medical Staff
R9-7-208. Provisional Medical Staff
R9-7-209. Clinic Assignments
R9-7-210. Suspension or Revocation of Participation, Staffing and Clinic Assignment

ARTICLE 3. MEDICALLY ELIGIBLE CONDITIONS

Article 2, consisting of Sections R9-7-301 through R9-7-306 adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

Former Article 3, consisting of Sections R9-7-301 through R9-7-303, repealed effective August 9, 1989.

Section
R9-7-301. Medically Eligible Conditions
R9-7-302. Special Medical Conditions
R9-7-303. Establishing Medical Eligibility
R9-7-304. Primary Condition Determination
R9-7-305. Change of Service or Scope of Review
R9-7-306. Discharge and Notification

ARTICLE 4. RESIDENCY AND FINANCIAL ELIGIBILITY REQUIREMENTS

Article 4, consisting of Section R9-7-401 through R9-7-412 adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

Section
R9-7-401. Initial Application
R9-7-402. Residency Requirements
R9-7-403. Age Requirement
R9-7-404. Financial Eligibility
R9-7-405. Adjusted Annual Income
R9-7-406. Earned Income
R9-7-407. Unearned Income
R9-7-408. Deductions from Income
R9-7-409. Payment Agreement
R9-7-410. Financial Eligibility Exceptions
R9-7-411. Health or Medical Insurance
R9-7-412. Redeterminations

ARTICLE 5. SCOPE OF SERVICES

Article 5, consisting of Section R9-7-501 through R9-7-505 adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

Section
R9-7-501. Scope of Medical Services
R9-7-502. Hospital Admission and Decertification
R9-7-503. Transfers
R9-7-504. Prior Authorization for Services
R9-7-505. Termination of Services

ARTICLE 6. PAYMENT FOR SERVICES

Article 6, consisting of Section R9-7-601 through R9-7-603 adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

Section
R9-7-601. Claims Submission
R9-7-602. Reimbursement Rates
R9-7-603. Enrollee Payments for Services

ARTICLE 7. GRIEVANCE AND APPEALS

Article 7, consisting of Section R9-7-701 through R9-7-703 adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

Section
R9-7-701. Enrollee and Applicant Grievances

R9-7-702. Review and Appeal
R9-7-703. Computation of Time

ARTICLE 1. DEFINITIONS

R9-7-101. Definitions

In this Article, unless the context otherwise requires:

1. "Acute Health Care" means emergency and follow-up health care provided in response to the initial stages of disease or injury.
2. "ADA" means the American Dental Association.
3. "AFDC" means the Aid for Dependent Children program administered by the Arizona Department of Economic Security.
4. "AHCCCS" means the Arizona Health Care Cost Containment System.
5. "Allowable charges" means the maximum amounts payable by CRS based on the Health Care Financing Administration Common Procedure Coding System for services by physicians and vendors, and on the AHCCCS reimbursement system for hospital services.
6. "ALTCS" means the Arizona Long-term Care System.
7. "Applicant" means a person for whom application to CRS is being made and the person's parents, legal guardian, legal custodian, or any person legally responsible to financially support the applicant if the applicant is under 18 years of age or otherwise under legal disability.
8. "Community Clinic" means a clinic held outside regional contractor sites but not on an Indian reservation.
9. "Contractor" means any non-state entity or person with whom CRS has contracted to provide specific services.
10. "Court-ordered child support" means payments made by the applicant, the applicant's parents and any other person legally obligated to provide for the care of the applicant for a minor child living outside of the household of the applicant as ordered by the Arizona Court for child support.
11. "CRS" means Children's Rehabilitative Services, a program administered by the Division of Family Health, Arizona Department of Health Services.
12. "CRS Clinic" means an established CRS clinic held at a regional contractor site.
13. "CRS Medical Director" or "Medical Director" means the person appointed by the Director to provide appropriate advice and counsel regarding medical matters to the CRS Office Chief, and any person specifically delegated in writing by the CRS Medical Director to exercise any or all of the CRS Medical Director's authority.
14. "CRS Office Chief" means the employee of the Department appointed to act as chief administrator for the Children's Rehabilitative Services program.
15. "Department" means the Arizona Department of Health Services.
16. "DES" means the Arizona Department of Economic Security.
17. "Earned income" means cash or in-kind received from the receipt of wages, salaries, commissions, or profit from activities in which an individual is engaged as an employee or self-employed person.
18. "Enrollee" or "CRS enrollee" means an applicant who has a CRS eligible medical condition confirmed at the 1st clinic visit, has completed both the CRS financial interview and signed a CRS Financial Agreement, and who has been determined as eligible for CRS and approved for participation in CRS.
19. "Family" means the applicant or enrollee, the applicant's or enrollee's parents and any other person legally responsible to financially support the applicant or enrollee.
20. "Family size" means the applicant, parents, or other persons legally responsible to financially support the applicant and their dependents who reside in the same household.
21. "Fee-for-Service" means a reimbursement method in which payment is made in accordance with a particular fee or rate for individual encounters in the CRS Program.
22. "FHAMIS" means the Family Health Automated Management Information System maintained by the Department.
23. "Field clinic" means a clinic held on an Indian reservation.
24. "Handicapping" means those physical impairments that limit 1 or more major life activities.
25. "HCPCS" means the Health Care Facilities Administration common procedure coding system which is incorporated by reference.
26. "Incapacitated adult" means a person over 18 years of age who is subject to a mental or physical disability as determined by a court or a physician.
27. "Major life activities" means caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.
28. "Medical Assistance" means the Title XIX portion of the AHCCCS program, which also includes S.O.B.R.A., Ribicoff and ALTCS programs.
29. "Medical staff" means all physicians and dentists employed by or under contract with CRS.
30. "Multidisciplinary clinic" means a clinic setting that utilizes more than 1 medical specialty physician in the treatment of an individual.
31. "Primary care provider" means the physician or other health care provider providing primary and acute health care for medical conditions not eligible under CRS.
32. "Primary condition" means a diagnosis which qualifies as a medically eligible condition for CRS services and which provides the medical eligibility component to qualify an applicant or enrollee to receive CRS services.
33. "Primary health care" means routine health care provided to prevent disease, treat injury or maintain general health.
34. "Regional Medical Director" means the physician appointed by the ADHS Director to provide appropriate input on medical issues to the regional administration, statewide medical executive committee and the CRS Office Chief, and any person specifically delegated in writing by the Regional Medical Director to exercise any or all of the Regional Medical Director's authority.
35. "RSDI" means benefits paid by the Social Security Administration under Title II of the Social Security Act to retired or disabled wage earners, or surviving children or spouses of wage earners.
36. "Seasonal worker" means a person who is regularly employed for less than a full 12 months each year or a person who is regularly employed for a full 12 months but who is not paid during each of the 12 months.
37. "S.O.B.R.A." means the 6th Omnibus Reconciliation Act and refers to a program which provides Medical Assistance to eligible pregnant women as soon as possible following verification of pregnancy, and provides Medical Assistance to eligible children born on or after October 1, 1983.
38. "Title XIX" means the Federal Medicaid Program which provides health care to financially eligible persons and

which is administered jointly by the U.S. Department of Health and Human Services and the state.

39. "Unearned income" means monies received for which no labors were expended, but does not include monies received from conversion of assets from one form to another.
40. "Vendor services" means services provided by agencies with which the Department directly contracts to provide services or equipment not covered under provider contracts.

Historical Note

Adopted effective August 9, 1989 (Supp. 89-3). Section repealed; new Section adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-102. Repealed

Historical Note

Adopted effective August 9, 1989 (Supp. 89-3). Repealed under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-103. Repealed

Historical Note

Adopted effective August 9, 1989 (Supp. 89-3). Repealed under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-104. Repealed

Historical Note

Adopted effective August 9, 1989 (Supp. 89-3). Section R9-7-104 and "Financial Eligibility Summary Table" repealed under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-105. Repealed

Historical Note

Adopted effective August 9, 1989 (Supp. 89-3). Repealed under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-106. Repealed

Historical Note

Adopted effective August 9, 1989 (Supp. 89-3). Repealed under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-107. Repealed

Historical Note

Adopted effective August 9, 1989 (Supp. 89-3). Repealed under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-108. Repealed

Historical Note

Adopted effective August 9, 1989 (Supp. 89-3). Repealed under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-109. Repealed

Historical Note

Adopted effective August 9, 1989 (Supp. 89-3). Repealed under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-110. Repealed

Historical Note

Adopted effective August 9, 1989 (Supp. 89-3). Repealed under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

ARTICLE 2. MEDICAL STAFF

R9-7-201. Provider Services; Participation

A. Physician and dental services delivered under contract to CRS enrollees shall be provided only by physicians and dentists who meet the terms and conditions of provider participation in CRS and who are placed on a Department roster pursuant to R9-7-202 and R9-7-203.

B. Each physician or dental provider contracting with CRS shall sign an acceptance of the terms and conditions of participation in CRS.

C. The Medical Director shall maintain the roster of all physician and dental providers who are eligible to provide CRS services.

D. Physicians and dental practitioners who are members of the medical staff and whose active status and assignment to a clinic have previously been determined prior to the effective date of R9-7-202, R9-7-203, R9-7-207(A), R9-7-208, and R9-7-209 shall be exempt from those rules. A member of the active staff who does not have a clinic assignment shall be similarly exempt except for R9-7-209. Physicians and dental practitioners who are members of the medical staff but who are on provisional status prior to the effective date of R9-7-202, R9-7-203, and R9-7-208. A shall be exempt from those rules.

E. Clinic assignments for physician or dental providers shall be based upon the need to ensure that necessary services to CRS enrollees are effectively and efficiently provided within CRS's appropriation.

F. A physician or dental practitioner shall not receive reimbursement for CRS billable services unless 1st rostered for participation with the Department.

Historical Note

Repealed effective August 9, 1989 (Supp. 89-3). Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-202. Application for Rostering

A. A physician or dental practitioner shall apply for CRS rostering by submitting an application to the CRS Regional Medical Director which shall then be reviewed and a recommendation

made by the CRS regional medical executive committee to the CRS Medical Director.

B. To be eligible for rostering and participation in CRS under the conditions of participation, a physician or dental practitioner shall:
1. Be a resident of Arizona and licensed to practice medicine or dentistry in the state;
2. Provide evidence of demonstrated competency in a CRS specialty by producing such documentation as may be requested and specified by the Medical Director regarding past medical outcomes, past medical diagnoses and past medical interventions;
3. Provide evidence of demonstrated skill and experience in the treatment of children;
4. Submit 3 sponsoring letters from specialists in the same specialty field as the candidate who are licensed to practice in Arizona, who are unrelated to and not currently associated with the candidate, but who have personal knowledge of the candidate's current clinical ability in the provision of care, ethical character, and ability to work cooperatively with others.

C. Physicians and dental practitioners who apply for rostering and participation in CRS shall provide CRS with evidence of the following:
1. For physicians and dental practitioners who provide CRS services in hospitals which also contract with CRS to provide services, medical malpractice insurance in such amounts as are required by those hospitals.
2. For physicians and dental practitioners not included in subsection (C)(1), medical malpractice insurance in such amounts as are required by the group or individual contract under which the physician or dental practitioner provides CRS services.
3. Current licensure.

D. In addition to (B) and (C), a physician applying for rostering shall comply with the following:
1. The physician shall provide evidence of appropriate training and experience in the CRS specialty in which the candidate anticipates participation, including evidence of board certification by a board recognized by the American Board of Medical Specialties or the American Board of Osteopathic Specialties, or evidence of eligibility for such boards.
2. A physician having no experience in the treatment of infants or young children but who otherwise complies with subsections (B)(1), (2), and (4), (C)(1), (2), and (3), and (D)(1) may be approved to supervise the care of children over 13 years of age.
3. Provisional rostering may be considered for a candidate who does not comply with subsection (D)(1) and who practices in a geographical area where there are no physicians rostered in the candidate's specialty, upon the candidate providing evidence of appropriate training and experience. Such evidence shall demonstrate that the criteria for the candidate's formal academic training is similar to the requirements of a specialty board recognized by the American Board of Medical Specialties or the American Board of Osteopathic Specialties. Provisional rostering shall be valid for a period of 2 years. A physician who is provisionally rostered shall qualify for board certification before the expiration of that time period or the physician shall be removed from rostering and participation. An extension of this time period may be granted for good cause by the CRS Medical Director.

E. In addition to (B) and (C), a dental practitioner applying for rostering shall comply with the following:
1. Provide evidence of board certification by a board recognized by the American Board of Orthodontics, the American Board of Prosthodontics or the American Board of Pediatric Dentistry; and
2. Have had either a minimum of 2 years of graduate training in orthodontics or prosthodontics or a recognized preceptorship training.

Historical Note

Repealed effective August 9, 1989 (Supp. 89-3). Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-203. Rostering Procedures; Exemptions

A. Following a review of an application and required documentation, a regional medical executive committee and the regional medical director shall submit a signed recommendation to the CRS Medical Director requesting approval or denial of rostering for the physician or dental practitioner. The recommendation shall verify that the regional medical executive committee has reviewed the candidate for compliance with all standards required by these rules for medical staff. The CRS Medical Director shall, in writing, grant or deny the application for rostering.

B. Rostering may be granted without review in exceptional circumstances by the CRS Medical Director:
1. Temporary rostering may be approved for a physician or dental practitioner by the CRS Medical Director. Requests for temporary rostering shall be made by the Regional Medical Director or chairperson of the contracted medical staff prior to the medical event which requires the services of the physician or dental practitioner. A physician or dental practitioner shall be allowed 2 temporary rostering events per year. Any further participation shall be allowed only after completion of the formal application for rostered status.
2. In emergency situations, a physician or dental practitioner who is not rostered may be utilized if a rostered physician or dental practitioner is not immediately available and approval is 1st secured from the CRS Medical Director either by phone with a follow-up by written documentation outlining the emergency, or in writing with adequate documentation. A failure to provide advance planning shall not constitute an emergency.

Historical Note

Repealed effective August 9, 1989 (Supp. 89-3). Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-204. Terms and Conditions of Participation for Physicians and Dental Practitioners

A. Physicians and dental practitioners who are approved for rostering and participation in CRS shall acknowledge and agree to the following terms and conditions:
1. There is no evidence of professional performance by the physician or dental practitioner which is not consistent with recognized standards of care or professional conduct. Further, there is no prior or current adverse action taken against the physician or dental practitioner based upon professional standards or performance grounds taken by a hospital medical board, a professional society, the Secretary of Health and Human Services, or by any

licensing or regulatory organization or court of competent jurisdiction.

2. The physician or dental practitioner shall maintain staff membership and admission privileges in good standing at the appropriate CRS-contracted regional clinics, regional hospital, or both, at which the physician's or dental practitioner's services are to be provided.
3. The physician or dental practitioner shall actively participate in CRS through clinics, office visits, consults, committees, or other functions as assigned by the Medical Director.
4. The physician or dental practitioner shall provide services in accordance with standards prescribed by state and federal laws and rules and regulations relating to CRS and Title XIX of the Social Security Act, and in the best interests of a CRS enrollee.
5. The physician or dental practitioner shall provide services in accordance with standards prescribed by national professional organizations for the care of handicapped children and in compliance with all CRS rules and policies.
6. The physician or dental practitioner shall provide only such treatment and services as are medically necessary and appropriate and covered under CRS, irrespective of contingent medical conditions, and which are within the scope of the provider's license and specialty.
7. The physician or dental practitioner shall provide services to enrollees only upon receipt of a written referral from the attending physician/clinic site.
8. The physician or dental practitioner shall coordinate the provision of covered services to enrollees by counseling, authorizing referrals for specific covered CRS services and providers, monitoring progress and managing utilization of services.
9. The physician or dental practitioner shall comply with CRS billing practices, including billing format, timeliness, 3rd-party collections and CRS reimbursement.
10. The contractor shall submit accurate and complete claims, using current CRS codes, modifiers, and forms.
11. The State is the payor of last resort. The physician or dental practitioner shall pursue collection from insurance companies and 3rd-party payors and may bill a family only that percentage of the CRS allowable charges which was determined to be the family's financial responsibility percentage when the family's financial eligibility was established. A physician or dental practitioner shall not bill a family which has a CRS financial responsibility of 0%, or more than a family's financial responsibility percentage of a CRS allowable charge. Percentage of family responsibility shall appear on all service authorization forms.
12. The physician or dental practitioner shall not bill AHCCCS for covered CRS services to AHCCCS-enrolled clients when such services have been authorized by CRS; nor shall the contractor bill enrollees, families or guardians for covered CRS services provided to AHCCCS enrollees.
13. The physician or dental practitioner shall make and maintain a record of service for each CRS-covered enrollee encounter.
14. The physician or dental practitioner shall submit service requisitions and report all CRS client services provided to CRS in accordance with CRS procedures.
15. The physician or dental practitioner shall obtain prior written authorization from CRS for all hospital admissions, outpatient surgeries, office visits and related medical procedures, except where emergency treatment is indicated.
16. If participating in CRS programs which involve instruction of medical residents or other similar educational components, the physician or dental practitioner shall abide by the medical and educational protocols approved by the Medical Director for such programs.

B. All physicians and dental practitioners who are rostered and participate in CRS shall, every 2 years, sign a form acknowledging the terms and conditions set forth in subsection A.

Historical Note

Repealed effective August 9, 1989 (Supp. 89-3). Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-205. Medical Executive Committees

A. There is established a statewide medical executive committee of physicians and dental practitioners, who are rostered and participate in CRS, to provide advice in the areas of CRS policy, quality assurance, utilization review, rostering, staffing and assignment of clinic privileges, and the suspension or revocation of rostering, staffing and clinic assignment to the CRS Medical Director, CRS Chief and the Director of the Department.

1. The committee shall consist of the president and vice presidents of each of the regional executive medical committees. The regional medical directors, the regional program administrators and the CRS Medical Director and Chief shall be non-voting members.
2. The statewide medical executive committee shall carry out its responsibilities in accordance with these rules and such bylaws as it may adopt and which are approved by the Director.

B. There is established a regional medical executive committee for each of the 4 regions/clinic sites, elected by the active medical staff serving each region, to provide advice to the Regional Medical Director and the Statewide Medical Executive Committee on issues of CRS policy, quality assurance, utilization review, rostering, staffing, and assignment of clinic privileges at the local clinic site.

1. Each regional medical executive committee shall consist of members of the active staff providing CRS services in the region who are elected by that staff, the Regional Medical Director and the chief administrator of the clinic site, both of the latter shall be non-voting members.
2. The regional medical executive committee shall determine and establish such offices, at a minimum to include a president and vice-president, number of members, terms of office and such bylaws as are necessary to carry out the responsibilities of the committee.

Historical Note

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-206. Medical Staff Assignment; Categories

The regional medical executive committee for the area in which a physician or dental practitioner offers services shall review the physician and dental practitioner application for staffing in accordance with the criteria set forth in R9-7-207 and R9-7-208 and shall make a recommendation to the Regional Medical Director regarding assignment of such applicant to the CRS medical staff as either active or provisional staff. The Regional Medical Director shall

transmit such recommendations to the CRS Medical Director who may approve or amend the recommendation.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-207. Active Medical Staff

A. Appointment to the active staff shall be based upon the following factors:
1. Length of service on the provisional staff, but not less than 2 years;
2. Need for additional physician or dental services on the active staff;
3. Evaluation of the provisional staff member's administrative or managerial skill;
4. Attendance and performance at staff meetings;
5. Attendance and performance while doing rounds;
6. Attendance and performance during surgery and at outpatient clinics;
7. Professional competence and clinical judgment in the treatment of patients;
8. Compliance with rules;
9. Ability to work effectively with patients, CRS personnel and the public;
10. The evaluation and recommendation of the chief or the senior member of the service involved; and
11. Length and quality of service on the medical staffs of other institutions comparable to CRS.

B. Members of the active medical staff may perform for CRS enrollees, without restriction, surgery and other professional services in accordance with their specialties and privileges. Except as otherwise provided by these rules, only active staff members shall be in charge of clinics. All business of the CRS medical staff shall be transacted by the active staff.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-208. Provisional Medical Staff

A. Those physicians or dental practitioners not assigned to the active staff shall be designated as provisional staff.

B. A provisional staff member may refer patients only from the member's own practice. Provisional staff shall not be assigned primary responsibility for the diagnosis and treatment of CRS enrollees referred from sources other than their own practices.

C. Provisional staff members may be assigned to areas of service where their activities may be observed by active staff. Provisional staff may assist in clinics and surgery and participate in teaching, rounds and meetings.

D. Provisional staff may be assigned to a clinic or placed in temporary charge of a clinic when no active staff qualified in the provisional staff member's specialty is available to meet the service need.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-209. Clinic Assignments

A. A member of the active staff may request appointment to a clinic assignment. The regional medical executive committee shall review such request in accordance with subsection B for purposes of making a recommendation to the Regional Medical Director for submission to the statewide medical executive committee regarding appointment. The statewide committee shall review the recommendation and make a recommendation to the Director regarding appointment to the clinic.

B. Clinic appointments shall be based upon the following criteria:
1. The physician's or dental practitioner's education and training,
2. The physician's or dental practitioner's experience,
3. Demonstrated competence by the physician or dental practitioner, and
4. References, including an appraisal by the clinic department in which privileges are sought.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-210. Suspension or Revocation of Participation, Staffing and Clinic Assignment

A. The Department may suspend or revoke the rostering and participation, staffing and clinic assignment of any physician or dental practitioner in CRS who violates any of the terms and conditions of participation set forth in R9-7-204(A), or any other rule set forth in this Chapter, after notice and opportunity for a hearing pursuant to A.R.S. § 41-1061 et seq. and the Department's rules of practice and procedure, 9 A.A.C. 1, Article 1.

B. Censure of a rostered and participating physician or dental practitioner by a national or local medical or dental society, or sanctions imposed by any state licensing board for physicians or dental practitioners shall constitute grounds for suspension or revocation of rostering and participation, staffing and clinic assignment.

C. If the Department finds that the health, safety or welfare of any CRS enrollee is jeopardized by any physician or dental practitioner rostered and participating in providing CRS services and that it imperatively requires emergency action, and incorporates a finding to that effect in its order, the summary suspension of rostering and participation, staffing and clinic assignment of such physician or dental practitioner may be ordered pending proceedings for revocation or other action. These proceedings shall be promptly instituted and determined.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

ARTICLE 3. MEDICALLY ELIGIBLE CONDITIONS

R9-7-301. Medically Eligible Conditions; Ineligible Conditions

A. Applicants with the following medical conditions shall be eligible for treatment by the CRS program:
1. Cerebral palsy,
2. Cleft lip and cleft palate,
3. Myelomeningocele (spina bifida),
4. Cystic fibrosis, and
5. Neurofibromatosis,
6. Metabolic diseases,
   a. Phenylketonuria,
   b. Galactosemia,
   c. Homocystinuria,

d. Hypothyroidism,
e. Maple syrup urine disease, and
f. Biotinidase deficiency.

7. Scoliosis,
8. Sickle cell anemia,
9. Cardiovascular system disorder:
   a. Congenital heart disease;
   b. Cardiomyopathies;
   c. Valvular disorders;
   d. Arrhythmias;
   e. Conduction defects;
   f. Rheumatic heart disease which is not in acute stage;
   g. Renal vascular hypertension, catecholamine hypertension;
   h. Arteriovenous fistulas; and
   i. Kawasaki disease which is not in the acute stage.
10. Endocrine system disorders:
    a. Hypothyroidism,
    b. Hyperthyroidism,
    c. Adrenogenital syndromes,
    d. Addison's Disease,
    e. Hypoparathyroidism,
    f. Hyperparathyroidism,
    g. Panhypopituitarism, and
    h. Diabetes insipidus.
11. Genito-urinary system disorders:
    a. Vesicoureteral reflux, chronic;
    b. Ectopic ureter;
    c. Ambiguous genitalia;
    d. Ureteral stricture;
    e. Hypospadias, complex;
    f. Obstructive uropathy, hydronephrosis;
    g. Deformity and dysfunction secondary to trauma; and
    h. Pyelonephritis which has failed medical management and requires surgical intervention.
12. Ear, nose, and throat disorders:
    a. Cholesteatoma;
    b. Chronic mastoiditis;
    c. Deformity and dysfunction secondary to trauma;
    d. Neurosensory hearing loss;
    e. Congenital malformations; and
    f. Significant conductive hearing loss equal to or greater than 30 decibels, pure bone average, which, despite medical treatment, requires hearing augmentation device.
13. Musculoskeletal system disorders:
    a. Osteochondrodysplasias:
       i. Achondroplasia,
       ii. Diastrophic,
       iii. Dwarfism, and
       iv. Larsen Syndrome.
    b. Juvenile rheumatoid arthritis and seronegative spondyloarthropathies,
    c. Orthopaedic complications of hemophilia, and
    d. Neuromuscular disorders:
       i. Progressive muscular dystrophy,
       ii. Arthrogryposis multiplex congenita, and
       iii. Spinal muscular atrophy.
    e. Bone and joint infections in a chronic stage,
    f. Upper limb malformations:
       i. Amputations and
       ii. Syndactly.
    g. Spinal deformity:
       i. Idiopathic scoliosis,
       ii. Congenital spine deformity,
       iii. Scheuermann's Disease, and
       iv. Spondylolisthesis.
    h. Cervical spine abnormalities, congenital and developmental, and
    i. Lower limb malformation:
       i. Leg length discrepancies,
       ii. Congenital deformity, and
       iii. Amputations.
    j. Collagen and vascular diseases.
14. Gastrointestinal system disorders:
    a. Tracheoesophageal fistula;
    b. Anorectal atresia;
    c. Hirschsprung's Disease;
    d. Diaphragmatic hernia;
    e. Gastroesophageal reflux which has failed medical management and requires surgical intervention;
    f. Deformity and dysfunction of at lease 3 months duration secondary to trauma;
    g. Biliary atresia;
    h. Congenital atresia, stenosis, fistuli or rotational abnormalities of the gastrointestinal tract; and
    i. Omphalocele after gastroschisis.
15. Nervous system disorders:
    a. Uncontrolled seizure disorders where there has been more than 2 seizures with documented adequate blood levels of 1 or more medications.
    b. Seizure disorders, simple or controlled, only when the enrollee is not covered by AHCCCS or private insurance.
    c. Myopathies and muscular dystrophies.
    d. Myoneural disorders.
    e. Neuropathies, hereditary and idiopathic.
    f. Central nervous system degenerative diseases.
    g. Central nervous system malformations and structural abnormalities.
    h. Hydrocephalus.
    i. Craniosynostosis of the sagittal or unilateral coronal sutures of a child less than 18 months of age.
    j. Myasthenia gravis, congenital or acquired.
    k. Benign intracranial tumor.
    l. Benign intraspinal tumor.
    m. Residual dysfunction after resolution of an acute stage of vascular accident, inflammatory condition or infection of the central nervous system.
    n. Tourette's Syndrome.
    o. Trigonotrigonocephly, with evidence of intracranial pressure as determined by medical review by the regional medical director.
16. Ophthalmologic disorders:
    a. Cataracts.
    b. Glaucoma.
    c. Disorders of the optic nerve.
    d. Disorders of the lacrimal duct system. AHCCCS members shall be treated through an AHCCCS provider.
    e. Retinopathy prematurity.
    f. Disorders of the iris, ciliary bodies, retina or lens.
17. Respiratory system disorders which manifest themselves as anomalies of larynx, trachea, and bronchi and which require surgical intervention.
18. Dermatologic disorders which are medically confirmed by the CRS Regional Medical Director:
    a. Craniofacial anomalies which require multidisciplinary treatments,
    b. Burn scars which are functionally limiting,
    c. Microtia which are grossly deforming,
    d. Macrotia which are grossly deforming,

e. Complicated nevi requiring staged procedure,
f. Hemangioma of functional or diagnostic concern, and
g. Craniosynostosis.

19. Genetic and metabolic disorders:
a. Amino acid and organic acidopathies,
b. Inborn errors of metabolism, and
c. Storage diseases.

20. Dental disorders:
a. Documented significant functional malocclusion;
b. Enrollees with shunts;
c. Cardiac enrollees at risk for septic bacterial endocarditis; and
d. Treatment-related problems (dilantin hyperplasia), for seizure disorder.

B. Any medical condition not specifically designated as eligible in this Section or in R9-7-302 is ineligible for treatment by CRS.

Historical Note
Repealed effective August 9, 1989 (Supp. 89-3). Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-302. Special Medical Conditions

A. Both children and adult CRS enrollees shall be covered for all manifestations and complications usually associated with cystic fibrosis and sickle cell anemia.

B. Adults with cystic fibrosis or sickle cell anemia who are AHCCCS eligible shall not be eligible for CRS services.

Historical Note
Repealed effective August 9, 1989 (Supp. 89-3). Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-303. Establishing Medical Eligibility

A. Upon receipt of the Pediatric History and Referral Form, a medical review of the case shall be completed by the Regional Medical Director to determine medical eligibility.

B. For those cases where eligibility is in question, the applicant shall submit to an evaluation in a CRS pediatric screening clinic or specialty clinic by a member of the CRS medical professional staff. The Regional Medical Director shall then determine if the applicant has a primary condition which is eligible for treatment in CRS. In cases where, following such examination, medical eligibility is still in question, the final determination regarding eligibility shall be referred to and determined by the CRS Medical Director.

Historical Note
Repealed effective August 9, 1989 (Supp. 89-3). Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-304. Primary Condition Determination

Applicants enrolled in an AHCCCS plan shall include with the Pediatric History and Referral form all pertinent documentation and diagnostic test results to establish the potential CRS primary condition. The CRS physician or clinic shall determine the need for any additional diagnostic testing at the time of the 1st clinic visit.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-305. Change of Service or Scope of Review

Referral of a CRS enrollee for a change in medical service or specialty not directly related to the current eligible medical condition shall be reviewed and documented by the Regional Medical Director.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-306. Discharge and Notification

Upon discharge from a CRS clinic, a CRS clinic patient discharge form shall be completed and placed in the discharged enrollee's chart by the regional contractor. Entry into the ADHS or clinic computer system shall be updated. Written notification shall be sent to parents, legal guardians, CRS and contracted eligibility workers.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

ARTICLE 4. RESIDENCY AND FINANCIAL ELIGIBILITY REQUIREMENTS

R9-7-401. Initial Application

A. A person shall apply for care under CRS by submitting a complete Pediatric History and Referral form and a CRS Financial Application to 1 of the CRS regional clinics for screening by the Regional Medical Director. If the applicant is enrolled in an AHCCCS program, the Pediatric History and Referral form shall include the applicant's primary diagnosis by the primary care physician and all diagnostic testing results used to determine the primary diagnosis.

B. Upon receipt, the Pediatric History and Referral form shall be reviewed by the Regional Medical Director within 3 working days unless additional medical records are requested to determine if the applicant has an eligible medical condition for treatment under the CRS Program.
1. If the condition claimed on the Pediatric History and Referral form is not a CRS eligible medical condition, a denial letter shall be sent to the applicant and the referral source by the CRS regional clinic.
2. If the medical condition is CRS eligible, a medical appointment shall be made and written notification shall be sent to the applicant and the referral source.

C. The applicant shall provide all necessary information to an on-site representative of DES or a CRS staff member to determine financial eligibility. An applicant shall complete the Medical Assistance Screening form if the applicant is not determined to be in the 100 % pay category or is not already receiving Title XIX assistance.

D. An applicant shall not be eligible to receive vendor services at the time of or after the initial clinic visit until the CRS financial determination has been made and the CRS financial agreement has been signed unless newborn screening is indicated.

E. At the 1st clinic visit, an applicant shall sign a general authorization to permit medical examination and other related procedures, tests and evaluations involving the applicant. If the parent, guardian or legal custodian cannot accompany a minor

applicant on the 1st clinic visit, the parent, guardian or legal custodian shall provide a signed and notarized medical consent form to accompany the minor.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-402. Residency Requirements

A. An applicant shall show written proof of residency. All applicants shall sign an affidavit stating current residency and intent to remain in Arizona at the initial CRS financial interview.

B. Arizona residency shall be established by providing 1 of the following types of documents:

1. Rent or mortgage receipt, or lease in the applicant's name showing the residential address.
2. Non-relative landlord statement indicating the applicant's name and address as well as the landlord's name and address and telephone, if available.
3. Statement from the nursing facility in which the applicant resides.
4. Arizona driver's license.
5. Arizona motor vehicle registration.
6. Employer's statement.
7. Utility bill in the applicant's name indicating the applicant's address.
8. Current phone directory showing applicant's name and address.
9. United States Post Office records which show the applicant's name and address.
10. A current city directory showing the applicant's name and address.
11. Certified copy of a church record which indicates the applicant's name and address.
12. Certified copy of a school record which indicates the applicant's current address.
13. If all reasonable efforts have been made by the applicant to obtain documented verification, the affidavit signed by the applicant attesting to the applicant's present residence in Arizona and intent to remain shall be sufficient.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-403. Age Requirement

An applicant shall provide proof of age at the initial CRS financial interview. Documents which may be used to verify age are as follows:

1. Alien documents;
2. Federal or state census records;
3. Hospital records of birth;
4. Certified copy of birth certificate;
5. Military records;
6. Notification of birth registration;
7. Religious records showing age or date of birth;
8. School records;
9. Affidavit signed by the licensed physician, licensed midwife or other health care professional who was in attendance at the time of the birth attesting to the date of birth;
10. U.S. Passport; and
11. If all reasonable efforts have been made by the applicant to obtain documented verification, an affidavit signed by the applicant may be accepted.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-404. Financial Eligibility

Every CRS applicant shall participate in a face-to-face financial interview with a designated CRS staff member or a DES on-site worker, except for applicants who are enrolled in a Title XIX AHCCCS program and who do not have insurance.

1. An applicant shall complete the CRS financial eligibility process and Medical Assistance screening.
2. If the applicant is requested to provide additional verification documentation, the applicant shall provide the required documentation and complete the eligibility process within 10 working days of receipt of the request.
3. An applicant shall sign the CRS Financial Agreement. If an applicant is a ward of the Arizona court or enrolled in an AHCCCS program, the CRS Financial Agreement shall be signed only if the applicant has insurance.
4. An applicant shall complete the CRS financial and Medical Assistance screening and sign the CRS Financial Agreement, if required, in order to receive services from the CRS Program beyond the 1st clinic visit.
5. A family's adjusted gross income shall be determined based upon verification of income and documented dental and medical bills and such deductions as are otherwise permitted by these rules. The percent of financial responsibility shall be determined by comparing the family's adjusted gross income and family size to the program's financial eligibility standards as specified in Table 1.
6. An applicant assigned to the 100% pay category who is not eligible for CRS services in accordance with R9-7-410 may elect to be screened to determine eligibility for Medical Assistance.
   a. If the applicant is found to be ineligible for Medical Assistance, a referral to the CRS clinic social services may be offered.
   b. If the applicant is found to be potentially eligible for Medical Assistance, the applicant shall complete the Medical Assistance application at the DES local site or at the CRS regional contractor site if CRS coverage is desired. If potentially eligible for ALTCS, the applicant shall attend an interview at an ALTCS office.
7. If a family is determined to be either partially financially responsible or having no financial responsibility, an applicant shall complete the Medical Assistance financial screening to receive CRS coverage:
   a. If the applicant is found to be potentially eligible for Medical Assistance, the applicant shall complete the Medical Assistance application at the DES local site or at the CRS Regional Contractor site if CRS coverage is desired.
   b. An applicant who does not complete the Medical Assistance application process shall be denied services. CRS shall enroll an applicant upon completion of the CRS financial interview and signing of the CRS Financial Agreement. An enrollee shall thereafter be terminated from services if the enrollee fails to complete the Medical Assistance application and eligibility process where the screening indicated the enrollee as potentially eligible for Title XIX services.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-405. Adjusted Annual Income; Percent Pay Category

A. A family's adjusted gross income shall be calculated in the following manner:
1. Total income, both earned and unearned, shall be calculated.
   a. For a family whose members receive wages or salaries or are unemployed, calculate the gross monthly earned income and determine annual earned income by multiplying the monthly amount by 12.
   b. For a family whose members are self-employed or seasonal workers, the previous year's annual earned income shall be used as the total earned income. If the self-employed applicant was not self-employed for a full year, annual earned income shall be calculated based upon those months of income since self-employment began.
2. Total medical and dental expenses, paid or unpaid, dependent care costs, adult or child, and the cost of employment deductions shall be determined for the past 12 months. If dependent care costs do not change monthly, then the total amount of dependent care cost shall be determined by multiplying 1 month's cost by 12.
3. Total income minus total expenses equals adjusted gross income.

B. The adjusted gross income and family size shall be compared to the Family Eligibility Summary Table to determine the percent pay category of the applicant.

C. Individuals who are enrolled in an AHCCCS health plan or AHCCCS program contractor shall be financially eligible at the 0 % payment category.

D. Wards of the Arizona court shall be financially eligible at the 0 % payment category.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-406. Earned Income

The following types of income shall be considered earned income for a family for purposes of determining eligibility for CRS applicants and shall be counted in the month of receipt:
1. Arizona Training Program salaries to handicapped persons working in a sheltered workshop;
2. Earnings from the Arizona Works! sponsored on-the-job training or Public Service Employment or from full or part-time job entries resulting out of participation in Arizona Works! but not including work incentive payments and reimbursements for training related expenses.
3. Earnings from baby-sitting, including DES day care;
4. Blood and plasma sales;
5. Can or bottle collections and sales;
6. Earnings received by applicants employed on a contractual basis;
7. Income earned as a housekeeper or home health care aide;
8. The value of any item which the applicant receives in return for labor expended;
9. Job Training Partnership Act earnings;
10. Jury pay;
11. Earned rental income, less expenses, received from rental property when work is involved;
12. Earnings from self-employment, calculated by taking the gross business receipts less business expenses;
13. Wages from Vocational Rehabilitation-sponsored on-the-job training;
14. Gross earnings from employment, including;
    a. Advances, bonuses and commissions;
    b. The amount of a reimbursement from an employer for a job-related expense which is in excess of the actual expense,
    c. Sick pay and vacation pay, and
    d. The actual amount of tip received.
15. Any other earned income received by the applicant which is not specifically excluded by R9-7-408 or any provision of state or federal law.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-407. Unearned Income

The following types of income shall be considered unearned income for a family for the purpose of determining eligibility for a CRS applicant and shall, unless otherwise specified, be counted in the month of receipt:
1. AFDC income;
2. Alimony or spousal maintenance;
3. Assistance payments received from General Assistance, Tuberculosis Control, and Emergency Assistance, or AFDC payments from another state.
4. Bureau of Indian Affairs payments:
   a. General Assistance Payments,
   b. Tribal Work Experience Program or Tribal Assistance Project Program except for the portion of the income which is an incentive payment,
   c. Work Study Program payments for living expenses paid directly to the student.
5. Child support received from the noncustodial parent in an amount in excess of $50 per child per month;
6. Cash contributions in excess of $50 per month unless the contribution is considered to be a loan;
7. The amount of an educational loan, scholarship, or grant remaining after subtracting applicable deductions shall be averaged for the period of months for which the loan, scholarship, or grant is intended to cover with the result constituting the monthly income;
8. Any Emergency Assistance received directly by an applicant or recipient of AFDC;
9. Small, nonrecurring cash gifts that exceed $500 per calendar year;
10. Payments received as compensation for an industrial injury, less any amounts paid as attorney fees.
11. Insurance payments or benefits:
    a. Medical insurance payments made directly to the insured.
    b. Insurance payments not designated as payment for a specific bill, debt or estimate.
    c. Insurance benefits which are used for, or are intended to meet, basic daily needs.
12. Interest, dividend and royalty payments made directly to the applicant. Funds left on deposit or converted into additional securities shall not be counted;
13. Gross lease payments or royalty from Indian land where an applicant owns or is allotted part of the reservation

land which the applicant may lease to others an applicant owns land that is not part of the reservation:
a. Land lease income shall be counted when it is received by the BIA and posted to the applicant's account, making it available for pick-up by the applicant.
b. If land lease income is available every month, it shall be counted monthly.
c. Land lease income that is received less frequently than monthly shall be considered income at the time it is available.
d. Funds in the BIA account prior to the month of application shall not be counted as income. All deposits of land lease moneys made after the application date shall be counted as income.

14. Legal settlements, less attorney's fees, which are not designated as payment for a specific bill, debt or estimate;
15. Payments received from mortgages, sales contracts or promissory notes shall be considered unearned income for the amount of payment which is interest;
16. Railroad Retirement Benefits;
17. Rental income generated solely from rental payments and not for services provided, less expenses;
18. Retirement income, pensions and annuities;
19. Social Security Administration benefits:
    a. Social Security benefits.
    b. Social Security Administration Educational Benefits for persons 18 to 22 years of age who are full-time students.
    c. RSDI Benefits paid to a representative payee on behalf of the applicant or the applicant's family and the payee lives in the same household as the applicant. When the representative payee does not live in the household, the RSDI Benefits shall be counted only to the extent that the payee makes them available for the support of the beneficiary.
20. Profits made on sales of stock;
21. Strike pay;
22. All payments received by the applicant or the applicant's family from a trust fund;
23. Unemployment Insurance benefits;
24. Veterans' Administration benefits;
25. VISTA income which exceeds the State or Federal minimum wage, whichever is greater;
26. Winnings from lotteries, bingo or any other form of gambling; and,
27. Other unearned income not excluded in R9-7-408 or any provision of state or federal law.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-408. Deductions from Income
The following amounts shall be deducted from income in determining CRS financial eligibility:

1. Medical and dental expenses
    a. Health insurance premiums paid by the family for any family member in the household within the previous 12 months.
    b. Unpaid medical and dental expenses incurred by any family member in the family's household prior to the date of application which are the family's financial responsibility and not subject to any applicable 3rd-party payment.
    c. Medical and dental expenses paid directly by the family for any family member in the household during the 12 months prior to the date of application and not subject to any applicable 3rd-party payment.
2. If the family received earned income and anticipates receiving earned income for the next 12 months, the cost of the care of a child or incapacitated adult, for whom written proof of the disability is provided, living in the same household shall be excluded from the amount as follows:
    a. Child care costs paid to any babysitter or day care provider.
        i. If all persons legally responsible for the financial support of the applicant are employed on a full-time basis (86 hours or more per month), up to $200.00 per month per child under 2 years of age shall be excluded. Up to $175.00 per month per child age 2 or older shall be excluded.
        ii. If all persons responsible for the care of the applicant are employed on a part-time basis (less than 86 hours per month), up to $100.00 per month per child under 2 years of age shall be excluded. Up to $88.00 per month per child age 2 or older shall be excluded.
    b. Incapacitated adult care costs paid to a provider for the care of an incapacitated adult shall be excluded as follows:
        i. If all of the persons legally responsible for the financial support of the applicant are employed on a full-time basis (86 hours or more per month), up to $175.00 per month shall be excluded.
        ii. If all persons legally responsible for the financial support of the applicant are employed on a part-time basis (less than 86 hours per month), up to $88.00 per month shall be excluded.
3. For any family member whose earned income is included in the adjusted gross income, $90.00 shall be deducted from earning each month for the cost of employment to compensate for job-related personal expenses.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-409. Payment Agreement

A. Each applicant not enrolled in AHCCCS shall complete and sign a payment agreement which shall provide for the following:
1. Acknowledgment of the family's financial responsibility for the determined percentage of the cost of CRS services delivered;
2. An assignment of insurance benefits to the CRS;
3. Than any moneys received by the applicant as a court award or settlement of a claim which provides for the medical care of the applicant shall be used to pay CRS providers for care which is authorized and provided;
4. When insurance benefits, court awards, claim settlements or other 3rd-party benefits are available, they shall be exhausted before CRS funds shall be used to provide care for the applicant or shall be used to reimburse CRS for all care provided to the applicant;
5. That if applicant receives and converts any benefits described by this subsection to the applicant's personal

use and not for payment of the applicant's CRS services, that applicant shall be personally responsible for the payment of the services for which the benefits were intended to pay.

B. An applicant who is a member of AHCCCS and who has insurance, a court award, a settlement, an unresolved claim relating to the applicant's CRS-eligible condition or other 3rd-party benefit shall sign the CRS payment agreement for purposes of subsection (A)(2) through (A)(5).

C. Unless the applicant is an AHCCCS member with no insurance, an applicant shall not be enrolled in CRS until a payment agreement has been completed.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-410. Financial Eligibility Exceptions

A. An applicant with an adjusted annual family income exceeding CRS financial eligibility limits shall be permitted to participate in CRS at the 100 % pay category upon meeting 1 of the following criteria:
1. The applicant is being treated for cerebral palsy, cleft lip or palate, adult cystic fibrosis, myelomeningocele, metabolic diseases, scoliosis, adult sickle cell anemia, or neurofibromatosis.
2. The applicant is 21 years of age and is in the process of completing an active intervention program approved by the CRS Medical Director that was initiated when the applicant was financially eligible.
3. The applicant requires specialty services which are not available elsewhere in the community;
4. The applicant has a CRS eligible medical condition of particular interest or rarity, other than the diagnoses specified in subsection (A)(1). CRS coverage for such case shall be requested, in writing, by the applicant's attending physician, and shall be approved on an individual basis by the Regional Medical Director in consultation with the CRS Office Chief and Medical Director.

B. An applicant who meets the requirements of this section shall complete the CRS financial interview and shall complete and sign a payment agreement. Such applicant shall not be required to complete a Medical Assistance screening but shall be offered the opportunity to complete this screen.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-411. Health or Medical Insurance; Court Awards

A. An enrollee shall make available to CRS all health or medical insurance benefits of any kind and moneys received as an award by a court or in settlement of a claim for damages for purposes of the care of an enrollee in order to pay CRS providers for the cost of care which is authorized and provided before the expenditure of any CRS funds for the services.

B. Enrollees who receive insurance or other 3rd-party payments for medical care received from CRS shall remit those payments to the CRS providers who rendered the care. An applicant who receives and converts any benefits described by this section to the applicant's personal use and not for payment of the applicant's CRS services shall be personally responsible for the payment of the services for which the benefits were intended to compensate.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-412. Redeterminations

A. All CRS enrollees who are receiving medical coverage provided by an AHCCCS health care plan, except those in ALTCS and SOBRA, shall complete a CRS financial eligibility redetermination every 6 months after the initial eligibility determination. Other CRS enrollees and ALTCS members shall complete a CRS financial eligibility determination once a year. Non-AHCCCS enrollees shall sign a CRS Financial Agreement at each redetermination during the financial eligibility interview.

B. A Notice for Redetermination shall be sent to non-AHCCCS enrollees prior to the expiration of financial eligibility informing the enrollee of the date eligibility expires, the requirement that the enrollee make an appointment for redetermination by the end of the current month, and the requirement that the applicant shall complete the redetermination prior to the expiration date of the CRS financial determination. The enrollee shall also be notified that if the redetermination is not completed by the expiration date, the medical coverage under CRS shall be suspended. Thereafter, the enrollee shall complete the financial eligibility redetermination before CRS medical services shall be reinstated.
1. If the enrollee is Title XIX or non-Title XIX AHCCCS recipient, other than ALTCS or S.O.B.R.A. pregnant woman, the 1st CRS redetermination shall be scheduled at the same time that the AHCCCS redetermination is due. Every 6 months thereafter, a combined redetermination shall be completed for CRS and Medical Assistance.
2. If the enrollee is an ALTCS member, the 1st redetermination shall be scheduled at the same time that the ALTCS redetermination is due. Every 12 months thereafter, a redetermination shall be completed for CRS and ALTCS.
3. If the enrollee is a S.O.B.R.A. pregnant woman, the CRS redetermination shall occur at the end of the post partum period. When a S.O.B.R.A. pregnant woman's S.O.B.R.A. eligibility is discontinued, a redetermination shall be completed no later than the end of the last month of S.O.B.R.A. eligibility. At that time, the enrollee shall be evaluated for both CRS and Medical Assistance eligibility.
4. In addition to the regularly scheduled redeterminations, a redetermination may be requested by an applicant or may be authorized by the CRS Chief at any time if there is reason to believe that the applicant's financial status has changed.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

Table 1. 1992 CRS Percent Pay Category Table

1992 CRS PERCENT PAY CATEGORY TABLE (APRIL 1, 1992 - MARCH 31, 1993)						
Size of Unit	0%	3%	6%	9%	12%	15%
1	0-6,810	6,811-8,810	8,811-10,810	10,811-12,810	12,811-14,810	14,811-16,810
2	0-9,190	9,191-11,190	11,191-13,190	13,191-15,190	15,191-17,190	17,191-19,190
3	0-11,570	11,571-13,570	13,571-15,570	15,571-17,570	17,571-19,570	19,571-21,570
4	0-13,950	13,951-15,950	15,951-17,950	17,951-19,950	19,951-21,950	21,951-23,950
5	0-16,330	16,331-18,330	18,331-20,330	20,331-22,330	22,331-24,330	24,331-26,330
6	0-18,710	18,711-20,710	20,711-22,710	22,711-24,710	24,711-26,710	26,711-28,710
7	0-21,090	21,191-23,090	23,091-25,090	25,091-27,090	27,091-29,090	29,091-31,090
8	0-23,470	23,471-25,470	25,471-27,470	27,471-29,470	29,471-31,470	31,471-33,470

For family units with more than 8 members, add $2,380 for each additional family member.

Historical Note

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

ARTICLE 5. SCOPE OF SERVICES

R9-7-501. Scope of Medical Services

The CRS program shall provide the following medical, surgical, and therapy modalities for CRS enrollees:

A. Hospital inpatient services.
1. CRS shall cover hospitalization only at the CRS contracted provider sites for enrollees with a CRS covered condition.
2. The contractor shall effect discharge planning upon admission.

B. Outpatient services.
1. The CRS prior authorization office shall determine if surgery may be performed on a outpatient basis. Prior written authorization shall be obtained.
2. The regional contractors shall be responsible for all authorized hospital or clinic-based outpatient services.

C. Dental and orthodontia services.
1. Services may be provided through CRS clinics or, where clinics are unavailable, through the practitioner's private office.
2. All dental and orthodontic treatment shall require prior written authorization by the CRS prior authorization office if provided outside the CRS clinic.

D. CRS enrollees shall receive physician services only from physicians who are rostered and approved to participate in the CRS program.

E. Clinic services.
1. An enrollee shall be assigned to receive authorized services for all CRS covered conditions at the CRS clinic closest to the enrollees residence:
   a. Clinic appointments shall be based upon a review of the enrollee's needs, the physician's request, and available appointment slots.
   b. Appointments shall be made on a non-priority basis.
2. Specialty and multidisciplinary clinics:
   a. CRS applicants may enter the CRS program directly into a specialty clinic only after an assessment and evaluation by the regional medical director or the regional medical director's designee authorized to determine medical eligibility.
   b. All specialty clinics shall be authorized by the Regional Medical Director.
3. Community and field clinics:
   a. All community and field clinics shall be authorized by the CRS Medical Director.
   b. All applicants to be seen in field clinics shall complete the Pediatric History and Referral Form, the CRS Financial Application and, where applicable, the Medical Assistance screening at the time of the 1st visit. The CRS Financial Agreement and the medical assistance determination must be completed and the applicant enrolled in CRS prior to the applicant being permitted any subsequent visits.
   c. An applicant shall not be eligible to receive vendor services at the time of or after the initial clinic visit until the required CRS financial determination has been made and the applicant has signed the CRS Financial Agreement.

F. Home health care services.
1. Home health care is provided to CRS enrollees where available and is limited to the post hospitalization rehabilitative or recovery period, not to exceed 30 calendar days. Requests for extension shall be submitted to and must be approved by the CRS Medical Director and coordinated with the CRS clinic.
2. Home health care may be provided by all CRS contracted health care providers in lieu of hospitalization if it has been determined medically appropriate by the Regional Medical Director. Such home health care shall not exceed 30 calendar days.
3. Total parental nutrition, home aides, and 24-hour nursing services are excluded from CRS home health services.

G. Diagnostic testing and laboratory services.
1. CRS enrollees who are not AHCCCS members may receive diagnostic testing services. Diagnostic testing for determining a CRS eligible primary condition shall not be a covered service unless approved by the Regional Medical Director.
2. Follow-up laboratory evaluations where discovered laboratory abnormalities are unrelated to the CRS eligible medical condition are not covered services. The CRS enrollee shall be referred to the primary care physician for follow-up care.

H. Nursing services.
1. Direct patient care,
2. Teaching, and,

3. Coordination and communication among CRS contractor staff and other community-based agencies.

I. Pharmaceuticals and medical supplies.
1. CRS enrollees shall receive pharmaceuticals and medical supplies for CRS covered conditions when ordered by a physician and when appropriate to the treatment of the CRS covered condition.
2. Covered pharmaceuticals and medical supplies shall include special formulation nutrition needs for metabolic patients. Pharmaceuticals or supplies that would normally be ordered by the primary care physician for the overall health maintenance of the enrollee are not covered.

J. Vision services.
1. Eyeglasses and contact lenses shall be provided only when ordered by the CRS physician for the purpose of treating a CRS covered condition.
2. Except for the initial prescription or revision of that prescription, CRS shall provide only 1-a-year replacement for broken or lost glasses or contact lenses.

K. Physical and occupational therapy services.
1. CRS enrollees shall receive physical and occupational therapy services only for the purpose of treating the CRS covered condition. Enrollees shall be evaluated in a CRS medical or surgical clinic to determine eligibility for therapy services. CRS shall not provide maintenance therapies.
2. Individual outpatient physical and occupational therapy services shall be offered, not to exceed 12 weeks or 24 sessions in total unless authorized by the CRS Medical Director, for 1 or any combination of the following categories:
   a. For enrollees who meet 1 or more of the following conditions:
      i. Pre- and post surgery and post-casting enrollees, neurologic or orthopaedic, who have received treatment through the CRS Program. Therapy services shall be initiated within 5 working days from referral.
      ii. Post prosthetic enrollees.
   b. For CRS enrollees for whom prognosis shall be positive for a change in functional status as a result of intervention and who meet 1 of the following conditions:
      i. Individuals age 5 and under who are not currently receiving direct therapy and have a chronic neurological impairment with a strong potential for rehabilitation related to equipment needs, family education, home exercise program, and the ability to be cared for by others.
      ii. Individuals 3 to 21 years of age for whom no other services are available or are referred by specialty clinics. Therapy services shall be initiated within 21 working days from referral.
3. Consultation sessions for assessment, therapy and training are available for caregivers of CRS enrollees, ages birth to 21, with moderate to severe impairment of functional skills, for whom no other services are available. The duration of services may not exceed 6 weeks or 6 sessions, unless authorized by the CRS Medical Director.

L. Speech and language therapy services.
1. Speech and language therapy services shall be available to CRS enrollees whose communication disorder is directly related to a CRS eligible condition. CRS shall not treat isolated speech or language disorders.
2. Speech and language therapy services shall be available for the following:
   a. Pre- and post-surgery enrollees or those enrollees with a hospital discharge recommendation for speech and language therapy.
   b. Individuals 5 years of age and under who are not currently receiving direct therapy services.
   c. Individuals 3 to 21 years of age for whom no other services are available or who may be referred by specialty clinics.
3. The duration of therapy in these categories shall not exceed 12 weeks or 24 sessions, unless otherwise authorized by the CRS Medical Director as medically necessary. Therapy services shall be initiated within 21 working days.
4. Enrolles who are receiving speech and language therapy through another program shall not be eligible to receive those services through CRS.

M. Equipment shall be available to an enrollee who is being followed in a CRS medical or surgical clinic for the purpose of rehabilitative care directly related to the CRS covered condition.
1. CRS shall provide and modify wheelchairs for enrollees, as well as ambulation assistive devices. Rehabilitative equipment shall be available for enrollees as follows:
   a. Rehabilitative equipment shall not duplicate or serve essentially the same purpose as existing equipment. Equipment shall not be changed when existing equipment is functional and can be repaired to ensure safety.
   b. Equipment shall be adjustable to accommodate growth whenever possible.
   c. The physical setting of the home shall accommodate the equipment.
   d. The family shall be able to care for and transport the equipment.
   e. Practical and functional use of the equipment by the enrollee shall be demonstrated and documented by the CRS clinic staff.
   f. Equipment used solely for school purposes is the responsibility of the local education agency.
   g. CRS shall not pay for repairs or maintenance of equipment which has been replaced by another device serving the same purpose.
   h. Equipment needs shall be met through recycled items if the item meets needed recommendations.
   i. Trays for wheelchairs shall be provided only if documentation proves that the need is directly related to improvement in functional skill level.
   j. Use of ambulation equipment or wheelchairs is limited to 30 calendar days unless an extension is requested of and approved by the CRS Medical Director.
2. The following items shall not be provided by CRS:
   a. Adaptive power switches for wheel chairs,
   b. Bathing aides,
   c. Bicycles,
   d. Car seats,
   e. Corner chairs,
   f. Crawlers,
   g. Cribs or beds,
   h. Dressing aides,
   i. Exercise mats,
   j. Feeder seats,
   k. Helmets,
   l. Medical supplies,
   m. Motorized caster carts,
   n. Motorized vehicles,

o. Motorized wheelchairs,
p. Pillows,
q. Ramps,
r. Roll chairs,
s. Rolls,
t. Sand bags,
u. Side lying positioner,
v. Standers,
w. Strollers,
x. Toileting aids,
y. Transfer aids,
z. Van lifts,
aa. Wedges for positioning,
bb. Weights,
cc. Wheelchair carriers, or
dd. Convenience accessories for mobility equipment.

3. Equipment maintenance policy.
   a. CRS shall pay for equipment modifications which are necessary because of the enrollee's growth or due to changes in the enrollee's orthopaedic or health needs. These modifications shall be made only after being recommended as needed by the physician or the physical or occupational therapist and approved by CRS.
   b. CRS shall not pay for routine maintenance due to normal wear and tear or for repairs needed because of improper use or neglect, unless medical necessity is documented by the CRS professional staff or contracted therapist. The enrollee's family shall be responsible to pay for these services privately or through other assistance which the enrollee receives.
4. Oxygen and related supplies shall be available to the enrollee from CRS when ordered by a CRS physician as necessary for the treatment of the CRS covered condition. Such services shall not exceed 30 days. Any requests for extensions shall be submitted to and approved by the CRS Medical Director.

N. Prosthetic and Orthotic devices.
1. CRS shall provide and repair prosthetic and orthotic devices for CRS enrollees. CRS shall provide for prosthetic and orthotic modifications which are necessary because of the enrollee's growth, or due to changes in the enrollee's orthopedic or health needs. Modifications shall be recommended as needed, by the physician or the physical or occupational therapist and shall be approved by the CRS Medical Director.
2. CRS shall provide and replace ocular prostheses for a CRS enrollees which are necessary because of the enrollee's growth or due to health needs.
3. Shoes shall not be provided by CRS.

O. Audiology services.
1. CRS shall provide audiology services to CRS enrollees who are hearing impaired or who are at risk for hearing impairment. The following services shall be offered through all regional CRS programs:
   a. Audiologic assessments; CRS may provide Brainstem Audiology Evoked Response evaluations at the request of the CRS physician.
   b. Hearing aid evaluations.
   c. Hearing aids shall be provided and are reevaluated annually at the CRS clinic. A hearing aid shall be replaced only once every 3 years unless 1 of the following exceptions is met:
      i. Change in hearing levels
      ii. Exceptional circumstances as determined by staff audiologists
      iii. If an enrollee loses a hearing aid before the end of the 3-year period, does not have insurance, and does not meet 1 of the exception criteria listed in subsection (O)(1) (a) or (b) above. Enrollee shall be fitted with a reconditioned or loaner hearing aid as available.
2. Individuals shall not be required to purchase insurance for hearing aids.
3. Accessory items such as dry aid kits, batteries and swimmer's ear molds are not covered by CRS. Only accessory items necessary for proper functioning and maintenance of hearing aids shall be provided by CRS.
4. Implantable bone conduction devices shall be provided on an individual basis upon prior authorization of the CRS Medical Director.
5. Tactile hearing aids shall be provided on an individual basis upon prior authorization of the CRS Medical Director. Each application for CRS coverage of a tactile hearing aid shall be submitted by the CRS audiologist to the CRS Medical Director for review and approval.
6. CRS shall not provide cochlear implants.

P. Educational services.
1. Hospitalized CRS enrollees may be provided educational services for the purpose of establishing educational needs and goals for the inpatient stay, when available from the local CRS contractor.
2. CRS enrollees may be provided with an educational liaison for enrollees in the outpatient clinic to coordinate services with school district staff and school nurses, when available from the local CRS contractor.

Q. Child Life Services.
1. CRS enrollees may receive structured child life activities when hospitalized, either in a playroom or at the bedside, or at the outpatient clinic waiting room or play areas for enrollees and siblings, when available from the local CRS contractor.
2. Child life activities may include:
   a. Group activities of expressive play;
   b. Pre-operative teaching and medical play designed to decrease fears while increasing understanding and confidence;
   c. Explanations comprehensible to the child of sequence, nature, and reasons for procedures and routines; and,
   d. Support and coping strategies for the child during painful procedures.

R. Nutrition services.
1. CRS contractors shall provide nutrition services for enrollees with special nutritional needs. Nutrition services shall be provided by a registered dietitian to enrollees with the following medical conditions:
   a. Metabolic diseases,
   b. Spina bifida,
   c. Cerebral palsy,
   d. Epilepsy,
   e. Cleft lip and palate, and
   f. Cystic Fibrosis.
2. No enrollee shall receive total parenteral nutrition for over 30 days unless an extension is approved by the CRS Medical Director.
3. CRS shall provide nutritional supplements on a limited basis upon referral from CRS physicians with consultation by a registered dietitian, as follows:
   a. Formulas for metabolic disorders that are treated by a special diet are covered in accordance with the following guidelines:

i. Specified formulas for treatment of metabolic disorders and formula component products.
ii. Quantity provided shall be as needed, based upon demands for growth and maintenance; to be determined by the registered dietitian.
iii. Duration shall be for as long as treatment through dietary modification continues, up to 21 years of age.
iv. Lactose-free formulas for galactosemia; infant formulas or milk products used in conjunction with modified amino acid formulas; low protein food products such as pasta, breads, and cookies for amino acid disorders are not covered.

b. Short term coverage for tube feedings shall be available when related to a primary CRS medical condition and no other resources or community nutrition support programs are available.
i. Commercially available tube feeding formulas shall be provided.
ii. The quantity shall be as needed, based upon demands for growth and maintenance; to be determined by the physician or registered dietitian.
iii. The duration shall be limited to 30 calendar days of coverage. An extension for coverage requires the approval of the Regional Medical Director.
iv. Tube feeding equipment shall be provided by CRS when deemed medically essential to provide adequate nutrition and such equipment is not covered by another provider's plan. Equipment may be provided by CRS while the formula is provided by another resource.
v. Foods and beverages recommended for blenderized recipes shall not be provided.

c. Short term coverage may be available for cystic fibrosis enrollees when appropriate growth and maintenance needs to be established with a supplemental product, and no other resources or community nutrition support programs are available:
i. Commercially available nutrition supplements for additional calories and other nutrients may be provided.
ii. The quantity shall be limited to approximately 50 percent of daily caloric needs as a supplement to a regular diet unless the cystic fibrosis enrollee is also being tube fed.
iii. The duration shall be limited to 30 calendar days of coverage. An extension for coverage requires the approval of the Regional Medical Director.
iv. Foods and beverages that constitute the enrollee's regular diet shall not be provided.

d. Other medical conditions which require nutrition supplementation may be covered if related to the enrollee's CRS primary condition.

S. Psychological services.
1. An enrollee shall receive psychological services upon referral by a CRS physician or a member of the professional staff to a board-certified CRS psychologist. An enrollee may receive short term crisis intervention, assessment, evaluation and referral. Psychological services are limited to 3 visits per calendar year and shall be related to the primary CRS condition. CRS shall not provide ongoing psychological counseling or services.
2. Psychiatric services shall be available only upon evaluation and referral of an enrollee by a CRS psychologist to a CRS psychiatrist. Psychiatric services shall be limited to 1 visit per calendar year related to the primary CRS condition.
3. Enrollees shall not receive ongoing psychiatric therapy. Enrollees shall be referred to an appropriate agency for ongoing services.

T. Social work services.
1. CRS shall provide coordination and discharge planning with the hospital social work department and nursing staff during all CRS enrollee inpatient hospitalization and shall coordinate with the outpatient CRS social worker for all CRS enrollee admissions.
2. Upon referral, CRS shall provide coordination, discharge planning and coordinating of admissions with the inpatient CRS social worker and attending multidisciplinary clinics in the outpatient clinic for enrollees and families.

U. CRS shall provide only corneal and incidental bone grafting transplants.

V. CRS covered services shall not be provided out-of-state unless all of the following are verified:
1. The medical specialty or the procedure is not available in Arizona;
2. Two CRS participating medical specialists of that specialty recommended out-of-state treatment;
3. The treatment is considered to be lifesaving or will result in significant functional improvement;
4. The Chief of CRS and the CRS Medical Director have approved.

W. CRS covered services shall not be available to applicants with a CRS-eligible condition who are in the hospital at the time of application. Such applicants shall be eligible for enrollment and CRS services only after discharge from the hospital.

X. Transportation shall not be a reimbursable service unless it is provided between CRS contracted hospitals and facilities and has the prior authorization of the CRS Medical Director.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-502. Hospital Admission and Decertification

A. Only CRS physicians may admit and treat enrollees:
1. Prior authorization shall be obtained for all admissions other than those of an emergency nature related to the CRS covered condition.
2. The hospitalization shall be directly related to the CRS condition.
3. CRS shall not provide long term care or hospitalization for the sole purpose of maintaining the enrollee.
4. CRS shall not provide long term care or hospitalization for weight gain or loss prior to surgery.

B. Decertification.
1. The contractor may request that an enrollee be decertified from a CRS authorized admission. If an extended hospital stay is the result of a non-CRS covered condition, and this was not identified during the discharge planning process, the contractor shall notify the Chief of the CRS Program, the AHCCCS plan if the enrollee is a member of AHCCCS, and other responsible parties.
2. The Chief of the CRS Program shall review the medical record and notify the contractor of a decision within 24 hours of the time of notification from the contractor. If permission is granted to decertify, the contractor shall

notify and coordinate with the AHCCCS plan if the enrollee is a member of AHCCCS, and shall notify the family and other responsible parties within 24 hours. The notification to all responsible parties shall allow 24 hours from the time of notification before the enrollee is decertified.

3. CRS shall give timely verbal notification to the attending physician that the physician's patient has been identified as no longer meeting CRS medical eligibility requirements, or that there has been a modification of coverage. If CRS will no longer be financially responsible for hospitalization or the physician component of care, the verbal notification shall include this information.
4. All elective and urgent hospital and ambulatory admissions are reviewed by the CRS prior-authorization office of the Department. During the course of admission, continued stay or retrospective review, if the enrollee is determined to be medically ineligible or ineligible for reimbursement, the following shall occur:
   a. CRS utilization review staff shall review the pertinent information with the CRS Medical Director or designee;
   b. The authorization status shall be changed to reflect decertification; and,
   c. CRS utilization review staff shall coordinate with the regional clinics and the contracting hospital regarding the change in authorization status. Notification of decertification shall be mailed to the attending physician and responsible parties.
5. Decertification may be appealed by the enrollee or the physician in accordance with these rules.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-503. Transfers

A. CRS shall cover hospital transfers for CRS enrollees only when the admission is for treatment directly related to the primary CRS eligible medical condition and the CRS Medical Director has authorized the transfer in advance.

B. The CRS Medical Director shall give prior authorization to transfer only between contracted CRS facilities and only for CRS enrollees who are medically and financially eligible, when the transportation is ordered by a CRS participating physician.

C. Upon prior approval, the transferring agency shall complete applications for transfers, whether verbal or written, and shall include full diagnostic information on the CRS eligible medical condition. Failure of the transferring agency to provide this information may result in back-transferring of the enrollee at the expense of the agency from which the enrollee is transferred.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-504. Prior Authorization for Services

A. Prior authorization shall be obtained by the provider for physician services and inpatient services. The provider shall be responsible for securing any necessary prior authorization.

B. Hospitals and physicians shall notify the CRS provider service office located at each regional contractor site within 24 hours from the time an enrollee appears at a CRS contracted facility or hospital for emergency services. A determination as to whether the services were "emergency services" shall be provided through retrospective medical review. If the date of notification falls on a weekend or holiday, notification shall be made on the 1st working day following the weekend or holiday.

C. The prior authorization process shall be conducted in the following manner:
1. A provider or physician shall complete the CRS Provider Services Requisition form and transmit it to the regional contractor site where the service is to be provided. CRS shall be notified as soon as a health care service is planned.
2. The following baseline demographic information shall be provided on the CRS Provider Services Requisition form:
   a. Requesting physician and Arizona Medical license number;
   b. Hospital or other CRS provider;
   c. Individual name and date of birth;
   d. Complete service category;
   e. Proposed date and service;
   f. Proposed service to be provided;
   g. Diagnosis, including both primary and service diagnosis;
   h. Narrative description of the indications for the proposed service;
   i. Name of surgeon and assistant surgeon, if applicable; and
   j. Signature of requesting physician and date of request.
3. The prior authorization registered nurse shall research each request and obtain medical case information as needed in order to certify the CRS medical eligibility for the particular health care service. The following service reviews shall take place for inpatient admission or ambulatory service:
   a. Determine if the service to be provided is related to the CRS eligible medical condition. Any condition or treatment other than for a CRS covered condition shall not be authorized.
   b. Review the baseline information provided in FHAMIS.
   c. Evaluate the indications for surgery as they relate to the CRS eligible medical condition. The prior authorization registered nurse shall confer with the CRS Medical Director when unable to certify a requested health care service. Adverse decisions shall only be rendered by the CRS Medical Director.
   d. The prior authorization nurse shall also assess the appropriate level of care, timeliness of the admission to avoid unnecessary preoperative days, and necessity for an assistant surgeon.
   e. The prior authorization nurse shall confer with the CRS Medical Director when unable to certify the requested health care service.
4. A contractor's provider service representative shall mail completed authorizations to the requesting provider or physician and facility on a daily basis.

D. All requests for prior authorization shall be reviewed by the CRS medical staff under the direction of the CRS Medical Director. A request for prior authorization shall be subject to the following review:
1. Verification of the individual's enrollment in the CRS Program;
2. Verification that the services are covered by CRS;

3. Verification of other insurance coverage to which the enrollee may be entitled, including any requirements for pre-certification by other carriers or liable parties;
4. Determination as to whether the requested services is medically necessary and appropriate; and
5. Determine as to whether the medical review requires additional supportive documentation and medical records.

E. Reimbursement shall be made only when documentation supports the claim and service rendered, regardless of prior authorization and the issuance of an authorization number.

F. An adverse prior authorization decision is appealable in accordance with the CRS grievance and appeal rules.

G. No authorization shall be given for any non-emergency or non-urgent service which has already been rendered. A CRS prior authorization nurse shall perform a retrospective analysis of these cases to determine if the health care service was urgent or emergent, or if it was elective or scheduled, and shall authorize accordingly.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-505. Termination of Service
CRS services shall terminate upon the occurrence of 1 of the following:

1. Enrollee establishes residence outside the state of Arizona.
2. Enrollee reaches the age of 21 years unless the enrollee is completing an approved course of treatment begun before the enrollee reached the age of 21, or is enrolled in the adult cystic fibrosis or sickle cell anemia programs.
3. Enrollee no longer has a medically eligible condition.
4. Enrollee is no longer financially eligible except as provided in R9-7-411.
5. Enrollee declines services.
6. Death of the enrollee.
7. Enrollee has not had a clinic visit for more than 1 year.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

ARTICLE 6. PAYMENT FOR SERVICES

R9-7-601. Claims Submission

A. Bills for services rendered shall be submitted to CRS within 6 months of the date of service. Claims received more than 6 months after the service has been rendered shall not be reimbursed.

B. Claims for service shall contain the following information:

1. Completion of all fields on the HCFA 1500 claim form;
2. The PSR authorization number;
3. Accurate HCPCS or ADA codes as unlisted HCPCS or ADA codes shall not be accepted;
4. Usual and customary charges, which shall be broken out for each HCPCS and ADA code submitted;
5. Accurate modifiers;
6. Operative report for surgical procedures;
7. Physicians' orders and progress notes for durable medical equipment;
8. All supportive documentation for services other than surgery; and,
9. All Explanations of Benefits that relate to the claim.

C. Claims submitted without the information required in subsection B or with inaccurate codes shall be returned to the provider along with a request for additional documentation to support the claim for proper resubmission or other disposition not later than 12 months following the date of service.

D. All regional site contractors shall adhere to billing requirements according to the terms of their contract.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-602. Reimbursement Rates
Reimbursement for services provided to CRS enrollees shall be as follows:

1. A contract provider shall be reimbursed by CRS according to the terms of the contract.
2. A non-contract provider shall be reimbursed by CRS on a fee-for-service basis, not to exceed the CRS usual and customary fees.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-603. Enrollee Payments for Services

A. The 1st clinic visit shall be provided at no cost to the family but shall be billed to 3rd-party payors, where applicable, or to a parent or other person legally responsible to financially support the applicant in the 100 % pay category.

B. After the 1st visit, families shall participate in the cost of care provided under the CRS Program at the percent pay category at which they have been determined. Insurance companies, other 3rd-party payors, or the family shall be billed for services.

1. The total for a billing for a family shall be determined by applying the family's percent pay obligation to the total allowable charges. Families who are in the 0 % pay category shall not be billed.
2. Insurance companies and other 3rd-party payors shall be billed the provider's usual and customary charges, without regard to the family's percent pay category.
3. Billings to families shall be issued directly by CRS or by the CRS contractor.
4. If insurance benefits or other payments made for CRS authorized services are paid directly to the family, the amount received from the insurance payment shall be sent immediately to CRS.

C. A family shall not be responsible for payment of otherwise covered services where the CRS provider has failed to obtain prior authorization from the CRS Medical Director.

D. The State of Arizona shall be the payor of last resort. Contract providers shall use all reasonable efforts to collect from insurance companies and 3rd-party payors. The contractor shall bill a family only that percentage of the CRS allowable charges which was determined to be the family's financial responsibility percentage when the family's financial eligibility was established. A physician or other provider shall not bill a family who has a CRS financial responsibility of 0%, or more than a family's financial responsibility percentage of a CRS allowable charge.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992;

filed in the Office of the Secretary of State June 8, 1998
(Supp. 98-2).

ARTICLE 7. GRIEVANCE AND APPEALS

R9-7-701. Enrollee and Applicant Grievances

A. An enrollee or applicant aggrieved by any adverse decision or action by a contractor may file a grievance as specified in this section. This section shall not apply to an action or decision affecting an enrollee's or applicant's financial eligibility or percent of financial participation for which the enrollee or applicant may file a grievance directly with the CRS Office Chief in accordance with R9-7-702.

B. Enrollee or applicant grievance to Contractor.

1. All grievances filed by enrollees or applicants relating to the contract shall be filed with the contractor for review, investigation and resolution in accordance with the contractor's internal grievance procedure.
2. All grievances shall be filed in writing with the contractor no later than 15 days after the date of the adverse decision or action.
3. The contractor shall record and retain sufficient information to identify the grievant, date of receipt, nature of the grievance, and the date and nature of the decision rendered.
4. A final decision shall be rendered by the contractor on grievances within 15 days of filing. A copy of the decision by the contractor shall be personally delivered or mailed by regular mail to all parties and shall state the basis for the decision as well as information regarding the enrollee's right to appeal the decision to the CRS Medical Director of Office Chief.
5. At the time of enrollment, each enrollee shall be given material explaining grievance procedures available through the contractor, CRS Medical Director, CRS Office Chief and the Director of the Department.

Historical Note

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-702. Review and Appeal

A. All CRS applicants, enrollees and all providers of services to CRS enrollees may request review of a final notice of an adverse decision issued by a CRS or its contractors.

1. Within 15 days of receipt of an adverse decision relating to medical condition or services, an applicant, enrollee or provider may submit a written request to the CRS Medical Director for review.
2. Within 15 days of receipt of an adverse decision relating to non-medical issues, an applicant, enrollee or provider may submit a written request to the CRS Office Chief for review.
3. The CRS Medical Director or Office Chief shall provide a written reply to the review request within 30 days of receipt of the request. Additional time may be necessary if medical records are required to complete the case analysis. The reply shall state whether the adverse decision has been upheld, modified or reversed. The reply shall be mailed to the requesting party and to other appropriate participating parties.

B. All CRS applicants, enrollees and providers of services to CRS enrollees may file a formal appeal, requesting a hearing, in response to any adverse reply from the CRS Medical Director or Office Chief to a review request.

1. An appeal shall be in writing and filed within 15 days of receipt of an adverse reply to a review request with the Office of the Director, Arizona Department of Health Services. The appeal shall clearly state in detail the basis of the grievance and the relief being requested.
2. The appeal shall be conducted in accordance with the Department's rules and practice and procedure, A.A.C., Title 9, Chapter 1, Article 1.

Historical Note

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

R9-7-703. Computation of Time

In computing any period of time prescribed or allowed by these rules, the day of the act, event or default after which the designated period of time begins to run shall not be included. The last day of the period shall be included unless it is a Saturday, Sunday or a state holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday, nor a state holiday. The computation shall include intermediate Saturdays, Sundays, and holidays.

Historical Note

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective June 30, 1992; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2).

TITLE 9. HEALTH SERVICES

CHAPTER 8. DEPARTMENT OF HEALTH SERVICES
FOOD, RECREATIONAL AND INSTITUTIONAL SANITATION

ARTICLE 1. FOOD AND DRINK

Section

R9-8-101. Reserved
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R9-8-103. Reserved
R9-8-104. Reserved
R9-8-105. Reserved
R9-8-106. Reserved
R9-8-107. Reserved
R9-8-108. Reserved
R9-8-109. Reserved
R9-8-110. Reserved
R9-8-111. Scope and legal authority
R9-8-112. Definitions
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R9-8-121. Non-specific places or operations; scope
R9-8-122. Non-specific places or operations; general
R9-8-123. Non-specific places or operations; physical plant
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R9-8-132. Food care
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R9-8-174. Bakeries; toilet and lavatory
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R9-8-178. Bakeries; storage; display; transportation
R9-8-179. Reserved
R9-8-180. Reserved
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R9-8-187. Refrigeration; packaging; transportation
R9-8-188. Processed meat and meat food product requirements for retail meat establishments
R9-8-189. Inspections
R9-8-190. Reserved
R9-8-191. Repealed

ARTICLE 2. BOTTLED WATER

New Article 2, consisting of Sections R9-8-201 through R9-8-209, adopted effective August 6, 1990 (Supp. 90-3).

Former Article 2 renumbered to Title 18, Chapter 4, Article 2.

Section

R9-8-201. Definitions
R9-8-202. Water quality and source
R9-8-203. Processing practices
R9-8-204. Labeling requirements
R9-8-205. Source water sampling
R9-8-206. Finished product sampling
R9-8-207. Transportation vehicles
R9-8-208. Certification and inspection
R9-8-209. Public nuisance

ARTICLE 3. PUBLIC TOILET FACILITIES

New Article 3, consisting of Sections R9-8-301 thru R9-8-308, adopted effective April 10, 1997 (Supp. 97-2).

Article 3, renumbered to Title 18, Chapter 9, Article 8 (Supp. 87-3).

Section
R9-8-301. Definitions
R9-8-302. Persons Responsible
R9-8-303. Constructing and Maintaining a Restroom or Bathroom
R9-8-304. Constructing and Maintaining a Portable Toilet

See Title 18, Chapter 8, Article 5.

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ARTICLE 6. CAMP GROUNDS

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R9-8-604. Reserved
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R9-8-607. Reserved
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ARTICLE 7. SCHOOLS

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R9-8-703. Reserved
R9-8-704. Reserved
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R9-8-847. Design standards and specifications; natural and semi-artificial bathing places
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ARTICLE 9. BEDDING

Article 9, consisting of Sections R9-8-901 thru R9-8-917, adopted effective October 30, 1998 (Supp. 98-4).

Section
R9-8-901. Definitions
R9-8-902. Bedding License Application
R9-8-903 Time-frames
R9-8-904. Issuance of License
R9-8-905. License Classification
R9-8-906. License Suspension or Revocation
R9-8-907. Off-sale Procedure
R9-8-908. Off-sale Tag Requirements
R9-8-909. Uniform Classification and Description of Filling Materials
R9-8-910. Prohibited Filling Materials
R9-8-911. General Requirements for a Bedding Tag
R9-8-912. Tag and Labeling Required on New Bedding
R9-8-913. Tag and Labeling Required on Renovated Bedding
R9-8-914. Tag and Labeling Required on Secondhand Bedding
R9-8-915. Treatment of Secondhand Bedding
R9-8-916. Treatment Record
R9-8-917. Recommended Treatment Methods

ARTICLE 10. RENUMBERED

See Title 18, Chapter 5, Article 4.

ARTICLE 11. REPEALED

Article 11, consisting of Section R9-8-1111, repealed effective April 10, 1997 (Supp. 97-2).

ARTICLE 12. RENUMBERED

See Title 18, Chapter 8, Article 6.

ARTICLE 13. HOTELS, MOTELS, AND TOURIST COURTS

Section
R9-8-1301. Reserved
R9-8-1302. Reserved
R9-8-1303. Reserved
R9-8-1304. Reserved
R9-8-1305. Reserved
R9-8-1306. Reserved
R9-8-1307. Reserved
R9-8-1308. Reserved
R9-8-1309. Reserved
R9-8-1310. Reserved
R9-8-1311. Legal authority
R9-8-1312. Definitions
R9-8-1313. Permits
R9-8-1314. Inspection
R9-8-1315. Notification of disease
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R9-8-1327. Reserved
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R9-8-1329. Reserved
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R9-8-1331. Bedding
R9-8-1332. Food service
R9-8-1333. Drinking water; ice
R9-8-1334. Refuse
R9-8-1335. Water supply
R9-8-1336. Toilet; lavatory
R9-8-1337. Sewage disposal

R9-8-1338. Plumbing

ARTICLE 14. REPEALED

Article 14, consisting of Sections R9-8-1411 thru R9-8-1413, repealed effective April 10, 1997 (Supp. 97-2).

ARTICLE 15. REPEALED

ARTICLE 16. REPEALED

ARTICLE 17. RENUMBERED

See Title 18, Chapter 8, Article 4.

ARTICLE 18. RENUMBERED

See Title 18, Chapter 8, Article 2.

ARTICLE 19. EMERGENCY EXPIRED

Article 19 consisting of Sections R9-8-1901 through R19-8-1905 adopted as an emergency effective June 18, 1984, pursuant to A.R.S. § 1-1003, valid for only 90 days (Supp. 84-3). Emergency expired. Language deleted (Supp. 87-2).

ARTICLE 1. FOOD AND DRINK

R9-8-101. Reserved

R9-8-102. Reserved

R9-8-103. Reserved

R9-8-104. Reserved

R9-8-105. Reserved

R9-8-106. Reserved

R9-8-107. Reserved

R9-8-108. Reserved

R9-8-109. Reserved

R9-8-110. Reserved

R9-8-111. Scope and legal authority

A. All food establishments shall comply with the provisions of this Article which are applicable to that particular type of establishment or to the foods provided by the establishment.

B. The regulations in this Article are adopted pursuant to the authority granted by A.R.S. §§ 36-132, 36-136, and 36-911.

Historical Note

Amended effective July 10, 1979 (Supp. 79-4).

R9-8-112. Definitions

In these regulations, unless the context otherwise requires:

1. "Adulteration". A food is adulterated if one or more of the conditions specified in A.R.S. § 36-904 exists.
2. "Approved" means acceptable to the Department.
3. "Commissary" means a catering establishment, restaurant, or any other place in which food, food containers, or food supplies are kept, handled, prepared, packaged, or stored.
4. "Corrosion-resistant materials" means those materials that maintain their original surface characteristics under prolonged influence of the food to be contacted, the normal use of cleaning compounds and bactericidal solutions, and other conditions-of-use environment.
5. "Department" means the Arizona Department of Health Services or a local, county, or city health department designated by the Director.
6. "Easily cleanable" means readily accessible and made of such materials and finish and so fabricated that residue may be effectively removed by normal cleaning methods.
7. "Employee" means the permit holder, individuals having supervisory or management duties and any other person working in a food establishment.
8. "Equipment" means stoves, ovens, ranges, hoods, slicers, mixers, meatblocks, tables, counters, refrigerators, sinks, dishwashing machines, steam tables, and similar items other than utensils, used in the operation of a food establishment.
9. "Food" means any raw, cooked, or processed edible substance, ice, beverage or ingredient used or intended for use or for sale in whole or in part for human consumption.
10. "Food-contact surface" means any surface of equipment or utensils with which food normally comes in contact and any surface from which food may drain, drip, or splash back onto surfaces normally in contact with food.
11. "Food establishment" means any place where food or beverage or any of the constituents thereof is produced, stored, manufactured, prepared, handled, sold or offered for sale or given away, including a food processing establishment and a food service establishment.
12. "Food processing establishment" means a commercial establishment in which food is manufactured or packaged for human consumption. The term does not include a food service establishment, retail food store, or commissary operation.
13. "Food service establishment" means any place where food is prepared and intended for individual portion service and includes the site at which individual portions are provided. The term includes any such place regardless of whether consumption is on or off the premises and regardless of whether there is a charge for the food. The term also includes delicatessen-type operations that prepare sandwiches intended for individual portion service. The term does not include private homes where food is prepared or served for individual family consumption, retail food stores, the location of food vending machines, and supply vehicles.
14. "Health officer" means the Director of the Department, a city health officer, a local health officer, or a county health officer.
15. "Hermetically sealed container" means a container designed and intended to be secure against the entry of microorganisms and to maintain the commercial sterility of its content after processing.
16. "Insanitary" means an unclean or unhealthful condition where food in the process of production, preparation, manufacture, packing, storing, sale, distribution or transportation is not protected from insects, flies, rodents, dust, dirt, or any other injurious contamination; or where refuse, dirt or waste products subject to decomposition and fermentation incident to the manufacture, preparation, packing, storing, selling, distributing, or transportation of food is not removed daily; or where all machinery, equipment and utensils are not maintained in a clean con-

dition; or where the clothing of employees is unclean; or where there exists any other circumstance determined by the Department to constitute a health hazard.

17. "Kitchenware" means all multi-use utensils other than tableware.
18. "Mislabeling or misbranding". A food is mislabeled or misbranded if one or more of the conditions specified in A.R.S. § 36-906 exists or if it does not conform to the labeling requirements of the Federal Act as defined in A.R.S. § 36-901.
19. "Mobile food unit" means a vehicle-mounted food service establishment designed to be readily movable.
20. "Packaged" means bottled, canned, cartoned, or securely wrapped.
21. "Person" means the state, a municipality, district, or other political subdivision, a cooperative, institution, corporation, company, firm, partnership, individual or other legal entity.
22. "Person in charge" means the individual present in a food service establishment who is the supervisor of the food service establishment at the time of inspection, or his designee. If no individual is the apparent supervisor, then any employee present is the person in charge.
23. "Potentially hazardous food" means any food that consists in whole or in part of milk or milk products, eggs, meat, poultry, fish, shellfish, edible crustacea, or other ingredients, including synthetic ingredients, in a form capable of supporting rapid and progressive growth of infectious or toxigenic microorganisms. The term does not include clean, whole, uncracked, odor-free shell eggs or foods which have a pH level of 4.6 or below or a water activity (a_w) value of 0.85 or less.
24. "Pushcart" means a non-self-propelled vehicle limited to serving non-potentially hazardous foods or commissary-wrapped food maintained at proper temperatures, or limited to the preparation and serving of frankfurters.
25. "Reconstituted" means dehydrated food products recombined with water or other liquids.
26. "Regulatory authority" means a local, county, or city health department with jurisdiction over a food service establishment; however nothing herein shall be deemed to limit
    a. the authority of the Director of the Arizona Department of Health Services to administer and enforce these regulations or assume any powers therein; or
    b. the authority of a local, county, or city health department to issue permits pursuant to local health regulations.
27. "Safe materials" means articles manufactured from or composed of materials that may not reasonably be expected to adversely affect, directly or indirectly, the characteristics of any food. If materials used are food additives or color additives as defined in Section 201(s) or (t) of the Federal Food, Drug, and Cosmetic Act, they are "safe" only if they are used in conformity with regulations established pursuant to Section 409 or Section 706 of the Act. Other materials are "safe" only if, as used, they are not food additives or color additives as defined in Section 201(s) or (t) of the Federal Food, Drug, and Cosmetic Act and are used in conformity with all applicable regulations of the Food and Drug Administration.
28. "Sanitization" means effective bactericidal treatment by a process that provides enough accumulative heat or concentration of chemicals for enough time to reduce the bacterial count, including pathogens, to a safe level on utensils and equipment.
29. "Sealed" means free of cracks or other openings that permit the entry or passage of moisture.
30. "Single-service articles" means cups, containers, lids, closures, plates, knives, forks, spoons, stirrers, paddles, straws, napkins, wrapping materials, toothpicks, and similar articles intended for one-time, one-person use and then discarded.
31. "Tableware" means multi-use eating and drinking utensils.
32. "Temporary food service establishment" means a food service establishment that operates at a fixed location for a period of time of not more than 14 consecutive days in conjunction with a single event or celebration.
33. "Uniform Mechanical Code" means the Uniform Mechanical Code published by the International Association of Plumbing and Mechanical Officials.
34. "Uniform Plumbing Code" means the Uniform Plumbing Code published by the International Association of Plumbing and Mechanical Officials.
35. "Utensil" means any implement used in the storage, preparation, transportation, or service of food.
36. "Wholesome" means clean, free from spoilage, and in such condition as to be safe for human consumption.

Historical Note
Former Section R9-8-112 repealed, new Section R9-8-112 adopted effective July 10, 1979 (Supp. 79-4).

R9-8-113. Prohibition
The floors, walls, ceilings, receptacles, implements, machinery, and equipment of every food establishment, and all vehicles used in the transportation of food shall not be kept or permitted to remain in an unclean, unhealthful, or insanitary condition.

R9-8-114. Minimum standards
When minimum standards of design and construction for a particular type of equipment have been formulated and published by the Department or the National Sanitation Foundation, only that equipment which is designed and constructed in accordance with the applicable standard may be installed as new or replacement equipment.

R9-8-115. Right of entry
No person shall refuse to admit the Health Officer, at any reasonable time, upon his request to any part of the establishment for the purpose of inspection and shall permit the copying of any or all records of foods purchased or disposed of.

R9-8-116. Examination and condemnation
Samples of food or drink may be taken and examined by the Health Officer as often as he deems necessary for the detection of unwholesomeness or adulteration. The Health Officer shall, at his discretion, condemn and forbid the sale, or cause to be removed or destroyed, food or drink which he deems unwholesome or adulterated.

R9-8-117. Refuse
All refuse shall be stored and disposed of in accordance with Article 4 of this Chapter of these regulations.

Historical Note
Corrected Article reference (Supp. 77-3).

R9-8-118. Plans
Plans for the construction, alteration, or remodeling of any food establishment shall be reviewed by the Health Officer for compliance with these regulations. No construction, alteration, or remodeling shall be undertaken until such plans have been approved.

R9-8-119. Permits

A. No person shall operate a food establishment without first procuring a permit to do so from the Health Officer. The permit shall be posted in a conspicuous place on the premises of the food establishment.
B. The permit shall be issued in the name of the owner, manager, or operator for a specific location and shall be nontransferable.
C. A permit issued by the Health Officer is good until suspended or revoked, which action may be taken if the establishment is found to be operating contrary to these regulations.
D. The operation of such an establishment without a permit, or the continued operation after a permit has been suspended or revoked, shall constitute a violation of this regulation.
E. Application for a permit shall be on a form prescribed by the Health Officer and shall contain the name and address of the applicant and whatever other information the Health Officer shall require to ascertain whether the applicant has the facilities and capabilities to operate in such a manner as to conform to this regulation.
F. Prior to the issuance of any permit, an inspection of the premises and equipment shall be made by the Health Officer and no permit shall be issued unless the premises and equipment conform to the requirements of these regulations. Inspection shall be made as frequently as necessary for compliance with these regulations but in no instance at intervals of longer than six months.

R9-8-120. Reserved

R9-8-121. Non-specific places or operations; scope
R9-8-122 through R9-8-127 are applicable to any business, place or operation in which food is processed, prepared, stored, handled, transported, sold or given away and for which specific regulations have not been adopted elsewhere in this Article.

R9-8-122. Non-specific places or operations; general
A. Approved and effective methods of insect and vermin control shall be used at all times.
B. All persons engaged in these occupations shall wear clean outer garments and shall keep their hands clean at all times while engaged in handling food, drink, utensils, or equipment. Persons, while engaged in preparing or handling food, shall not use tobacco in any form. Hairnets are required for female personnel; caps shall be worn by males where required.
C. The premises of all food establishments shall be kept clean and free of litter or rubbish. None of the operations connected with a food handling establishment shall be conducted in any room used for domestic purposes. Adequate lockers and dressing rooms shall be provided for employees' clothing and shall be kept clean. Soiled linens, coats and aprons shall be kept in covered containers provided for this purpose.

R9-8-123. Non-specific places or operations; physical plant
A. The building shall be of sound, tight construction and dust proof.
B. The floors shall be constructed of impervious material where they are subject to flooding, spillage, or other conditions of hard use. All floors shall be easily cleanable, smooth, and, where necessary, graded to drain. They shall be kept clean and in good repair. The juncture of floors and walls shall be coved for easier cleaning.
C. Walls and ceilings of all rooms shall be kept clean and in good repair. All walls and ceilings of rooms in which food is stored or prepared shall be finished in a light color. The walls and ceilings of all rooms in which food is prepared or utensils washed shall have a smooth, washable surface.
D. All openings into the outer air shall be effectively screened and doors shall be self-closing, unless other approved means are provided to control insects and vermin.
E. All rooms in which food is stored, prepared, or in which equipment is washed shall be kept well lighted. Inspection points shall be lighted to the degree necessary to meet product inspectional requirements.
F. All rooms in which food is stored, prepared, or served, or in which utensils are washed, shall be properly ventilated at all times.

R9-8-124. Non-specific places or operations; water supply
A. All water shall be obtained from a safe, sanitary supply, and from an approved source. Hot and cold running water shall be provided in all rooms in which products are processed or prepared or utensils are washed.
B. Any connection or condition, including overhead leakage, that may permit an interchange of water between a public water supply and a private, industrial, or other source of water supply is prohibited unless both supplies and the method of cross-connection or condition have been approved in writing by the Department.
C. No plumbing fixture or other device which provides, or may provide, a connection between a drinking water supply and a drainage, soil, waste, or other sewer pipe so as to make possible the backflow of sewage or waste water into the water supply system shall be installed or permitted to remain installed. Water which has been used for cooling or for any other purpose shall not be returned to the system unless the entire installation and operation thereof has been approved in writing by the Department. All plumbing shall be installed in accordance with any local ordinance or code and with the standards adopted by reference in R9-1-412(D).

R9-8-125. Non-specific places or operations; toilets and lavatories
A. Adequate and convenient toilet facilities shall be provided for employees. They shall conform to the requirements of the Department. The doors of all toilet rooms shall be self-closing. Toilet rooms shall be kept clean, in good repair, well lighted, and ventilated to the outside air. Hand-washing signs shall be posted in each toilet room used by employees.
B. Adequate and convenient hand-washing facilities shall be provided, including hot and cold running water, soap, and approved individual sanitary towels. Lavatories, in addition to those provided in toilet rooms, shall be provided and shall be easily accessible to all employees. Mixing faucets are required in new construction or when the existing plant is remodeled. No employee shall resume work after using the toilet room without washing his hands. Lavatories and wash rooms shall be kept clean and sanitary.

R9-8-126. Non-specific places or operations; utensils and equipment
A. All piping, vats, utensils, and all counters, shelves, refrigerating equipment, sinks, and any other equipment or utensils, used in connection with the operation of any business covered by this regulation, shall be so constructed as to be easily cleaned and shall be kept in good repair. Only approved piping shall be used. Enamelware and graniteware are prohibited. Utensils or equipment which are cadmium lead or other toxic material is a part of the metal are prohibited. The equipment shall be so located and installed as to facilitate the cleaning of both the equipment and the area in which it is installed.
B. All equipment, including but not limited to, windows, counters, shelves, vats, tables, refrigerators, and sinks shall be kept clean and free from dust, dirt, insects, and all contaminating material. All multi-use equipment and utensils used in the preparation or processing of food or food products shall be thoroughly cleaned immediately following the day's operation and shall be subjected to an approved bactericidal treatment

immediately prior to reuse. An approved bactericidal treatment shall consist of one of the following methods:

1. Steam - large equipment and pipe lines may be sanitized by being sprayed with live, dry (15 No. relative pressure with pipe vented until live steam reaches end) steam or may be circulated through a pipe.
2. Utensils or the product zone of equipment or pipe system may be sanitized by means of being dipped into, swabbed, sprayed, or recirculated by a chlorine solution. Minimum strength of chlorine solution shall be 100 ppm free chlorine.
3. Such other methods or chemicals, as approved by the Health Officer in writing, may be used.

C. After cleaning, utensils and equipment shall be properly stored in a clean dry place, protected from insects and vermin, dust, and other types of contamination. Containers and packaging materials shall be purchased in clean containers, stored in a clean, dry area, and in such a manner as to preclude contamination.

R9-8-127. Non-specific places or operations; wholesomeness and storage of food and drink

A. All food and drink shall be clean, wholesome, free from spoilage, and so prepared as to be safe for human consumption. Perishable food or products shall be refrigerated so that the food temperature does not exceed 45°F. at any time except during actual processing. Subsequent to processing, the food shall be returned to refrigeration in the minimum amount of time consistent with the preservation of the quality of the food and good processing techniques. Ice shall be from approved sources, stored, and handled in a sanitary manner.

B. All food and drink shall be stored, displayed, and served so as to be protected from dust, insects, vermin, depredation and pollution by rodents, handling, droplet infection, overhead leakage, and other contamination. No live animals or birds shall be kept or allowed in any room in which food or drink is prepared, stored, or served.

R9-8-128. Reserved

R9-8-129. Reserved

R9-8-130. Reserved

R9-8-131. Food service establishments

The provisions of R9-8-131 through R9-8-140 apply only to food service establishments, including mobile food service and temporary food service establishments. Said provisions are derived from the Food Service Sanitation Manual (1976) of the United States Department of Health, Education, and Welfare (DHEW Publication No. (FDA) 78-2081) and shall to the extent practicable be construed consistently with the provisions and comments set forth in the Manual.

Historical Note

Former Section R9-8-131 repealed, new Section R9-8-131 adopted effective July 10, 1979 (Supp. 79-4).

R9-8-132. Food care

A. Food supplies
1. General
   a. Food shall be in sound condition, free from spoilage, filth, or other contamination and shall be safe for human consumption. Food shall be obtained from sources that comply with all laws relating to food and food labeling. The use of food in hermetically sealed containers that was not prepared in a food processing establishment is prohibited.
2. Special requirements
   a. Fresh and shucked shellfish (oysters, clams, or mussels) shall be packed in nonreturnable packages identified with the name and address of the original shell stock processor, shucker-packer, or repacker, and the interstate certification number issued according to the U.S. Public Health Service Certification Program. Shell stock and shucked shellfish shall be kept in the container in which they were received until they are used. Each container of unshucked shell stock (oysters, clams, or mussels) shall be identified by an attached tag that states the name and address of the original shell stock processor, the kind and quality of shell stock, and an interstate certification number issued by the state or foreign shellfish control agency.
   b. Only clean, whole eggs, with shell intact and without cracks or checks, or pasteurized liquid, frozen or dry eggs or pasteurized dry egg products shall be used, except that hard-boiled, peeled eggs, commercially prepared and packaged, may be used.

B. Food protection
1. General
   a. At all times, including while being stored, prepared, displayed, served, or transported, food shall be protected from potential contamination, including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs, sneezes, flooding, drainage, and overhead leakage or overhead drippage from condensation. The temperature of potentially hazardous food shall be 45°F. or below or 140°F. or above at all times, except as otherwise provided in this Article.
2. Emergency occurrences
   a. In the event of a fire, flood, power outage, or similar event that might result in the contamination of food, or that might prevent potentially hazardous food from being held at required temperatures, the person in charge shall immediately contact the regulatory authority. Upon receiving notice of this occurrence, the regulatory authority shall take whatever action that it deems necessary to protect the public health.

C. Food storage
1. General
   a. Food, whether raw or prepared, if removed from the container or package in which it was obtained, shall be stored in a clean covered container except during necessary periods of preparation or service. Container covers shall be impervious and nonabsorbent, except that linens or napkins may be used for lining or covering bread or roll containers. Solid cuts of meat shall be protected by being covered in storage, except that quarters or sides of meat may be hung uncovered on clean sanitized hooks if no food product is stored beneath the meat.
   b. Containers of food shall be stored a minimum of 6 inches above the floor in a manner that protects the food from splash and other contamination and that permits easy cleaning of the storage area, except that:
      i. Metal pressurized beverage containers and cased food packaged in cans, glass or other waterproof containers need not be elevated when the food container is not exposed to floor moisture; and

ii. Containers may be stored on dollies, racks or pallets, provided such equipment is easily movable.

c. Food and containers of food shall not be stored under exposed or unprotected sewer lines or water lines, except for automatic fire protection sprinkler heads that may be required by law. The storage of food in toilet rooms or vestibules is prohibited.

d. Food not subject to further washing or cooking before serving shall be stored in a way that protects it from cross-contamination from food requiring washing or cooking.

e. Packaged food shall not be stored in contact with water or undrained ice. Wrapped sandwiches shall not be stored in direct contact with ice.

f. Unless its identity is unmistakable, bulk food such as cooking oil, syrup, salt, sugar, or flour not stored in the product container or package in which it was obtained shall be in a container identifying the food by common name.

2. Refrigerated storage

a. Enough conveniently located refrigeration facilities or effectively insulated facilities shall be provided to assure the maintenance of potentially hazardous food at required temperatures during storage. Each mechanically refrigerated facility storing potentially hazardous food shall be provided with a numerically scaled indicating thermometer, accurate to ±3°F., located to measure the air temperature in the warmest part of the facility and located to be easily readable. Recording thermometers, accurate to ±3°F., may be used in lieu of indicating thermometers.

b. Potentially hazardous food requiring refrigeration after preparation shall be rapidly cooled to an internal temperature of 45°F. or below. Potentially hazardous foods of large volume or prepared in large quantities shall be rapidly cooled, utilizing such methods as shallow pans, agitation, quick chilling, or water circulation external to the food container so that the cooling period shall not exceed 4 hours. Potentially hazardous food to be transported shall be prechilled and held at a temperature of 45°F. or below unless maintained in accordance with R9-8-132(C)(3).

c. Frozen food shall be kept frozen and should be stored at a temperature of 0°F. or below.

d. Ice intended for human consumption shall not be used as a medium for cooling stored food, food containers or food utensils, except that such ice may be used for cooling tubes conveying beverages or beverage ingredients to a dispenser head. Ice used for cooling stored food and food containers shall not be used for human consumption.

3. Hot storage

a. Enough conveniently located hot food storage facilities shall be provided to assure the maintenance of food at the required temperature during storage. Each hot food facility storing potentially hazardous food shall be provided with a numerically scaled indicating thermometer, accurate to ±3°F., located to measure the air temperature in the coolest part of the facility and located to be easily readable. Recording thermometers, accurate to ±3°F., may be used in lieu of indicating thermometers. Where it is impractical to install thermometers on equipment such as bainmaries, steam tables, steam kettles, heat lamps, cal-rod units, or insulated food transport carriers, a product thermometer must be available and used to check internal food temperature.

b. The internal temperature of potentially hazardous foods requiring hot storage shall be 140°F. or above except during necessary periods of preparation. Potentially hazardous food to be transported shall be held at a temperature of 140°F. or above unless maintained in accordance with R9-8-132(C)(2)(b).

D. Food preparation

1. General

a. Food shall be prepared with the least possible manual contact, with suitable utensils, and on surfaces that prior to use have been cleaned, rinsed and sanitized to prevent cross-contamination.

2. Raw fruits and raw vegetables

a. Raw fruits and raw vegetables shall be thoroughly washed with potable water before being cooked or served.

3. Cooking potentially hazardous foods

a. Potentially hazardous foods requiring cooking shall be cooked to heat all parts of the food to a temperature of at least 140°F., except that:

i. Poultry, poultry stuffing, stuffed meats and stuffings containing meat shall be cooked to heat all parts of the food to at least 165°F. with no interruption of the cooking process.

ii. Pork and any food containing pork shall be cooked to heat all parts of the food to at least 150°F.

iii. Rare roast beef shall be cooked to an internal temperature of at least 130°F., and rare beef steak shall be cooked to a temperature of 130°F. unless otherwise ordered by the immediate consumer.

4. Liquid, frozen, dry eggs and egg products

a. Liquid, frozen, dry eggs and egg products shall be used only for cooking and baking purposes.

5. Reheating

a. Potentially hazardous foods that have been cooked and then refrigerated shall be reheated rapidly to 165°F. or higher throughout before being served or before being placed in a hot food storage facility. Steam tables, bainmaries, warmers, and similar hot food holding facilities are prohibited for the rapid reheating of potentially hazardous foods.

6. Nondairy products

a. Nondairy creaming, whitening, or whipped agents may be reconstituted on the premises only when they will be stored in sanitized, covered containers not exceeding one gallon capacity and cooled to 45°F. or below within 4 hours after preparation.

7. Product thermometers

a. Metal stem-type numerically scaled indicating thermometers, accurate to ±2°F., shall be provided and used to assure the attainment and maintenance of proper internal cooking, holding, or refrigeration temperature of all potentially hazardous foods.

8. Thawing potentially hazardous foods

a. Potentially hazardous foods shall be thawed:

i. In refrigerated units at a temperature not to exceed 45°F., or

ii. Under potable running water of a temperature of 70°F. or below, with sufficient water velocity to agitate and float off loose food particles into the overflow; or

iii. In a microwave oven only when the food will be immediately transferred to conventional cooking facilities as a part of continuous cooking process or when the entire uninterrupted cooking process takes place in the microwave oven; or
iv. As part of the conventional cooking process.

E. Food display and service
1. Potentially hazardous food
   a. Potentially hazardous foods shall be kept at an internal temperature of 45°F. or below or at an internal temperature of 140°F. or above during display and service, except that rare roast beef shall be held for service at a temperature of at least 130°F.
2. Milk and cream dispensing
   a. Milk and milk products for drinking purposes shall be provided to the consumer in an unopened, commercially filled package not exceeding 1 pint in capacity or drawn from a commercially filled container stored in a mechanically refrigerated bulk milk dispenser. Where a bulk dispenser for milk and milk products is not available and portions of less than 1/2 pint are required for mixed drinks, cereal, or dessert service, milk and milk products may be poured from a commercially filled container of not more than 1/2 gallon capacity.
   b. Cream or half and half shall be provided in an individual service container, protected pour-type pitcher or drawn from a refrigerated dispenser designed for such service.
3. Nondairy product dispensing
   a. Nondairy creaming or whitening agents shall be provided in an individual service container, protected pour-type pitcher, or drawn from a refrigerated dispenser designed for such service.
4. Condiment dispensing
   a. Condiments, seasonings and dressings for self-service use shall be provided in individual packages, from dispensers, or from containers protected in accordance with R9-8-132(E)(8).
   b. Condiments provided for table or counter service shall be individually portioned, except that catsup and other sauces may be served in the original container or pour-type dispenser. Sugar for consumer use shall be provided in individual packages or in pour-type dispensers.
5. Ice dispensing
   a. Ice for consumer use shall be dispensed only by employees with scoops, tongs, or other ice-dispensing utensils or through automatic self-service, ice-dispensing equipment. Ice-dispensing utensils shall be stored on a clean surface or in the ice with the dispensing utensil's handle extended out of the ice. Between uses, ice transfer receptacles shall be stored in a way that protects them from contamination. Ice storage bins shall be drained through an air gap.
6. Dispensing utensils
   a. To avoid unnecessary manual contact with food, suitable dispensing utensils shall be used by employees or provided to consumers who serve themselves. Between uses during service, dispensing utensils shall be:
      i. Stored in the food with the dispensing utensil handle extended out of the food; or
      ii. Stored clean and dry; or
      iii. Stored in running water; or
      iv. Dispensing utensils and malt collars used in preparing frozen desserts may be stored either in a running water dipper well or clean and dry.
7. Re-service
   a. Once served to a consumer, portions of leftover food shall not be served again except that packaged food, other than potentially hazardous food, that is still packaged and is still in sound condition, may be re-served.
8. Display equipment
   a. Food on display shall be protected from consumer contamination by the use of packaging or by the use of easily cleanable counter, serving line or salad bar protector devices, display cases, or by other effective means. Enough hot or cold food facilities shall be available to maintain the required temperature of potentially hazardous food on display.
9. Re-use of tableware
   a. Re-use of soiled tableware by self-service consumers returning to the service area for additional food is prohibited. Beverage cups and glasses are exempt from this requirement.

F. Food transportation
1. General
   a. During transportation, food and food utensils shall be kept in covered containers or completely wrapped or packaged so as to be protected from contamination. Foods in original individual packages do not need to be over-wrapped or covered if the original package has not been torn or broken. During transportation, including transportation to another location for service or catering operations, the requirements of this Article relating to food protection and food storage shall be followed.

Historical Note
Adopted effective July 10, 1979 (Supp. 79-4).

R9-8-133. Personnel

A. Employee health
1. General
   a. No person, while infected with a disease in a communicable form that can be transmitted by foods or who is a carrier of organisms that cause such a disease or while afflicted with a boil, an infected wound, or an acute respiratory infection shall work in a food service establishment in any capacity in which there is a likelihood of such person contaminating food or food-contact surfaces with pathogenic organisms or transmitting disease to other persons.

B. Personal cleanliness
1. General
   a. Employees shall thoroughly wash their hands and the exposed portions of their arms with soap and warm water before starting work, during work as often as necessary to keep them clean, and after smoking, eating, drinking, or using the toilet. Employees shall keep their fingernails clean and trimmed.

C. Clothing
1. General
   a. The outer clothing of all employees shall be clean.
   b. Employees shall use hair restraints which prevent any possibility of hair entering into food or contaminating food-contact surfaces.

D. Employee practices
1. General

a. Employees shall consume food only in designated dining areas. An area shall not be designated as an employee dining area if consuming food there may result in contamination of other food, equipment, utensils, or other items needing protection.
b. Employees shall not use tobacco in any form while engaged in food preparation or service nor while in areas used for equipment or utensil washing or for food preparation. Employees shall use tobacco only in designated areas. An area shall not be designated as an employee tobacco-use area if the use of tobacco there may result in contamination of food, equipment, utensils, or other items needing protection.
c. Employees shall handle soiled tableware in a way that minimizes contamination of their hands.
d. Employees shall maintain a high degree of personal cleanliness and shall conform to good hygienic practices during all working periods in the food service establishment.

Historical Note
Adopted effective July 10, 1979 (Supp. 79-4).

R9-8-134. Equipment and utensils

A. Materials
1. General
   a. Multi-use equipment and utensils shall be constructed and repaired with safe materials, including finishing materials; shall be corrosion resistant and non-absorbent; and shall be smooth, easily cleanable, and durable under conditions of normal use. Single-service articles shall be made from clean, sanitary, safe materials. Equipment, utensils, and single-service articles shall not impart odors, color, or taste nor contribute to the contamination of food.
2. Solder
   a. If solder is used, it shall be composed of safe materials and be corrosion resistant.
3. Wood
   a. Hard maple or equivalently nonabsorbent material that meets the general requirements set forth in R9-8-134(A)(1) may be used for cutting blocks, cutting boards, salad bowls, and baker's tables. Wood may be used for single-service articles, such as chop sticks, stirrers, or ice cream spoons. The use of wood as a food-contact surface under other circumstances is prohibited.
4. Plastics
   a. Safe plastic or safe rubber or safe rubber-like materials that are resistant under normal conditions of use to scratching, scoring, decomposition, crazing, chipping and distortion, that are of sufficient weight and thickness to permit cleaning and sanitizing by normal dishwashing methods, and which meet the general requirements set forth in R9-8-134(A)(1) are permitted for repeated use.
5. Mollusk and crustacea shells
   a. Mollusk and crustacea shells may be used only once as a serving container. Further re-use of such shells for food service is prohibited.
6. Single-service
   a. Re-use of single-service articles is prohibited.

B. Design and fabrication
1. General
   a. All equipment and utensils, including plasticware, shall be designed and fabricated for durability under conditions of normal use and shall be resistant to denting, buckling, pitting, chipping, and crazing.
   i. Food-contact surfaces shall be easily cleanable, smooth, and free of breaks, open seams, cracks, chips, pits, and similar imperfections, and free of difficult-to-clean internal corners and crevices. Cast iron may be used as a food-contact surface only if the surface is heated, such as in grills, griddle tops, and skillets. Threads shall be designed to facilitate cleaning; ordinary "V" type threads are prohibited in food-contact surfaces, except that in equipment such as ice makers or hot oil cooking equipment and hot oil filtering systems, such threads shall be minimized.
   ii. Equipment containing bearings and gears requiring unsafe lubricants shall be designed and constructed so that the lubricant cannot leak, drip, or be forced into food or onto food-contact surfaces. Only safe lubricants shall be used on equipment designed to receive lubrication of bearings and gears on or within food-contact surfaces.
   iii. Tubing conveying beverages or beverage ingredients to dispensing heads may be in contact with stored ice; provided that such tubing is fabricated from safe materials, is grommeted at entry and exit points to preclude moisture (condensation) from entering the ice machine or the ice storage bin, and is kept clean. Drainage or draining tubes from dispensing units shall not pass through the ice machine or the ice storage bin.
   iv. Sinks and drain boards shall be self-draining.
2. Accessibility
   a. Unless designed for in-place cleaning, food-contact surfaces shall be accessible for cleaning and inspection:
      i. Without being disassembled; or
      ii. By disassembling without the use of tools; or
      iii. By easy disassembling with the use of only simple tools such as a mallet, a screwdriver, or an open-end wrench kept available near the equipment.
3. In-place cleaning
   a. Equipment intended for in-place cleaning shall be so designed and fabricated that:
      i. Cleaning and sanitizing solutions can be circulated throughout a fixed system using an effective cleaning and sanitizing regimen; and
      ii. Cleaning and sanitizing solutions will contact all interior food-contact surfaces; and
      iii. The system is self-draining or capable of being completely evacuated.
4. Pressure spray cleaning
   a. Fixed equipment designed and fabricated to be cleaned and sanitized by pressure spray methods shall have sealed electrical wiring, switches, and connections.
5. Thermometers
   a. Indicating thermometers required for immersion into food or cooking media shall be of metal stem type construction, numerically scaled, and accurate to ±2°F.
6. Non-food contact surfaces

a. Surfaces of equipment not intended for contact with food but which are exposed to splash or food debris or which otherwise require frequent cleaning shall be designed and fabricated to be smooth, washable, free of unnecessary ledges, projections, or crevices, and readily accessible for cleaning, and shall be of such material and in such repair as to be easily maintained in a clean and sanitary condition.

7. Ventilation hoods
   a. Ventilation hoods and devices shall be designed to prevent grease or condensation from collecting on walls and ceilings and from dripping into food or onto food-contact surfaces. Filters or other grease extracting equipment shall be readily removable for cleaning and replacement if not designed to be cleaned in place.
8. Existing equipment
   a. Equipment that was installed in a food service establishment prior to the effective date of this Section, and that does not fully meet all of the design and fabrication requirements of this Section, shall be deemed acceptable in that establishment if it is in good repair, capable of being maintained in a sanitary condition, and the food-contact surfaces are nontoxic. Replacement equipment and new equipment acquired after the effective date of this Section shall meet the requirements of this Article.

C. Equipment installation and location
1. General
   a. Equipment, including ice makers and ice storage equipment, shall not be located under exposed or unprotected sewer lines or water lines, open stairwells, or other sources of contamination. This requirement does not apply to automatic fire protection sprinkler heads that may be required by law.
2. Table mounted equipment
   a. Equipment that is placed on tables or counters, unless portable, shall be sealed to the table or counter or elevated on legs to provide at least a 4-inch clearance between the table or counter and equipment and shall be installed to facilitate the cleaning of the equipment and adjacent areas.
   b. Equipment is portable within the meaning of R9-8-134(C)(2)(a) if:
      i. It is small and light enough to be moved easily by one person; and
      ii. It has no utility connection, or has a utility connection that disconnects quickly, or has a flexible utility connection line of sufficient length to permit the equipment to be moved for easy cleaning.
3. Floor-mounted equipment
   a. Floor-mounted equipment, unless readily movable shall be:
      i. Sealed to the floor; or
      ii. Installed on a raised platform of concrete or other smooth masonry in a way that meets all the requirements for sealing or floor clearance; or
      iii. Elevated on legs to provide at least a 6-inch clearance between the floor and equipment, except that vertically mounted floor mixers may be elevated to provide at least a 4-inch clearance between the floor and equipment if no part of the floor under the mixer is more than 6 inches from cleaning access.
   b. Equipment is easily movable if:
      i. It is mounted on wheels or casters; and
      ii. It has no utility connection or has a utility connection that disconnects quickly, or has a flexible utility line of sufficient length to permit the equipment to be moved for easy cleaning.
   c. Unless sufficient space is provided for easy cleaning between, behind and above each unit of fixed equipment, the space between it and adjoining equipment units and adjacent walls or ceilings shall be not more than 1/32 inch; or, if exposed to seepage, the equipment shall be sealed to the adjoining equipment or adjacent walls or ceilings.
4. Aisles and working spaces
   a. Aisles and working spaces between units of equipment and walls shall be unobstructed and of sufficient width to permit employees to perform their duties readily without contamination of food or food-contact surfaces by clothing or personal contact. All easily movable storage equipment such as pallets, racks, and dollies shall be positioned to provide accessibility to working areas.

Historical Note
Adopted effective July 10, 1979 (Supp. 79-4).

R9-8-135. Cleaning, sanitization and storage of equipment and utensils

A. Equipment and utensil cleaning and sanitization
1. Cleaning frequency
   a. Tableware shall be washed, rinsed, and sanitized after each use.
   b. To prevent cross-contamination, kitchenware and food-contact surfaces of equipment shall be washed, rinsed, and sanitized after each use and following any interruption of operations during which time contamination may have occurred.
   c. Where equipment and utensils are used for the preparation of potentially hazardous foods on a continuous or production-line basis, utensils and the food-contact surfaces of equipment shall be washed, rinsed, and sanitized at intervals throughout the day on a schedule based on food temperature, type of food, and amount of food particle accumulation.
   d. The food-contact surfaces of grills, griddles, and similar cooking devices and the cavities and door seals of microwave ovens shall be cleaned at least once a day; except that this shall not apply to hot oil cooking equipment and hot oil filtering systems. The food-contact surfaces of all cooking equipment shall be free of encrusted grease deposits and other accumulated soil.
   e. Non-food contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles and other debris.
2. Wiping cloths
   a. Cloths used for wiping food spills on tableware, such as plates or bowls being served to the consumer, shall be clean, dry and used for no other purpose.
   b. Moist clothes or sponges used for wiping food spills on kitchenware and food-contact surfaces of equipment shall be clean and rinsed frequently in one of the sanitizing solutions permitted in R9-8-135(A)(3) and used for no other purpose. These cloths and

sponges shall be stored in the sanitizing solution between uses.

c. Moist clothes or sponges used for cleaning non-food contact surfaces of equipment such as counters, dining table tops and shelves shall be clean and rinsed as specified in R9-8-135(A)(2)(b) and used for no other purpose. These cloths and sponges shall be stored in the sanitizing solution between uses.

3. Manual cleaning and sanitization
   a. For manual washing, rinsing and sanitizing of utensils and equipment, a sink with not fewer than three compartments shall be provided and used. Sink compartments shall be large enough to permit the accommodation of the equipment and utensils, and each compartment of the sink shall be supplied with hot and cold potable running water. Fixed equipment and utensils and equipment too large to be cleaned in sink compartments shall be washed manually or cleaned through pressure spray methods.
   b. Drain boards or easily movable dish tables of adequate size shall be provided for proper handling of soiled utensils prior to washing and for cleaned utensils following sanitizing and shall be located so as not to interfere with the proper use of the dishwashing facilities.
   c. Equipment and utensils shall be preflushed or prescraped and, when necessary, presoaked to remove gross food particles and soil.
   d. Except for fixed equipment and utensils too large to be cleaned in sink compartments, manual washing, rinsing, and sanitizing shall be conducted in the following sequence:
      i. Sinks shall be cleaned prior to use.
      ii. Equipment and utensils shall be thoroughly washed in the first compartment with a hot detergent solution that is kept clean.
      iii. Equipment and utensils shall be rinsed free of detergent and abrasives with clean water in the second compartment.
      iv. Equipment and utensils shall be sanitized in the third compartment according to one of the methods included in R9-8-135(A)(3)(e)(i) through (iv).
   e. The food-contact surfaces of all equipment and utensils shall be sanitized by:
      i. Immersion for at least one-half (1/2) minute in clean, hot water at a temperature of at least 170°F.; or
      ii. Immersion for at least one minute in a clean solution containing at least 50 parts per million of available chlorine as a hypochlorite and at a temperature of at least 75°F.; or
      iii. Immersion for at least one minute in a clean solution containing at least 12.5 parts per million of available iodine and having a pH not higher than 5.0 and at a temperature of at least 75°F.; or
      iv. Immersion in a clean solution containing any other chemical sanitizing agent allowed under 21 Code of Federal Regulations 178.1010 that will provide the equivalent bactericidal effect of a solution containing at least 50 parts per million of available chlorine as a hypochlorite at a temperature of at least 75°F. for one minute; or
      v. Treatment with steam free from materials or additives other than those specified in 21 Code of Federal Regulations 173.310 in the case of equipment too large to sanitize by immersion, but in which steam can be confined; or
      vi. Rinsing, spraying, or swabbing with a chemical solution of at least twice the strength required for that particular sanitizing solution under R9-8-135(A)(3)(e)(iv) in the case of equipment too large to sanitize by immersion.
   f. When hot water is used for sanitizing, the following facilities shall be provided and used:
      i. An integral heating device or fixture installed in, on, or under the sanitizing compartment of the sink capable of maintaining the water at a temperature of at least 170°F.; and
      ii. A numerically scaled indicating thermometer, accurate to ±3°F., convenient to the sink for frequent checks of water temperature; and
      iii. Dish baskets of such size and design to permit complete immersion of the tableware, kitchenware, and equipment in the hot water.
   g. When chemicals are used for sanitization, they shall not have concentration higher than the maximum permitted under 21 Code of Federal Regulations 178.1010 and a test kit or other device that accurately measures the parts per million concentration of the solution shall be provided and used.
4. Mechanical cleaning and sanitizing
   a. Cleaning and sanitizing may be done by spray-type or immersion dishwashing machines or by any other type of machine or device if it is demonstrated that it thoroughly cleans and sanitizes equipment and utensils. These machines and devices shall be properly installed and maintained in good repair. Machines and devices shall be operated in accordance with manufacturers' instructions, and utensils and equipment placed in the machine shall be exposed to all cycles. Automatic detergent dispensers, wetting agent dispensers, and liquid sanitizer injectors, if any, shall be properly installed and maintained.
   b. The pressure of final rinse water supplied to spray-type dishwashing machines shall not be less than 15 no more than 25 pounds per square inch measured in the water line immediately adjacent to the final rinse control valve. A 1/4-inch IPS valve shall be provided immediately upstream from the final rinse control valve to permit checking the flow pressure of the final rinse water.
   c. Machine or water line mounted numerically scaled indicating thermometers, accurate to ±3°F., shall be provided to indicate the temperature of the water in each tank of the machine and the temperature of the final rinse water as it enters the manifold.
   d. Rinse water tanks shall be protected by baffles, curtains, or other effective means to minimize the entry of wash water into the rinse water. Conveyors in dishwashing machines shall be accurately timed to assure proper exposure times in wash and rinse cycles in accordance with manufacturers' specifications attached to the machine.
   e. Drain boards shall be provided and be of adequate size for the proper handling of soiled utensils prior to washing and of cleaned utensils following sanitization and shall be so located and constructed as not to interfere with the proper use of the dishwashing

facilities. This does not preclude the use of easily movable dish tables for the storage of soiled utensils or the use of easily movable dish tables for the storage of clean utensils following sanitization.

f. Equipment and utensils shall be flushed or scraped and, when necessary, soaked to remove gross food particles and soil prior to being washed in a dishwashing machine unless a prewash cycle is a part of the dishwashing machine operation. Equipment and utensils shall be placed in racks, trays, or baskets, or on conveyors, in a way that food-contact surfaces are exposed to the unobstructed application of detergent wash and clean rinse waters and that permits free draining.

g. Machines (single-tank, stationary-rack, door-type machines and spray-type glass washers) using chemicals for sanitization may be used: Provided, that,
   i. The temperature of the wash water shall not be less than 120°F.
   ii. The wash water shall be kept clean.
   iii. Chemicals added for sanitization purposes shall be automatically dispensed.
   iv. Utensils and equipment shall be exposed to the final chemical sanitizing rinse in accordance with the manufacturers' specifications for time and concentration.
   v. The chemical sanitizing rinse water temperature shall be not less than 75°F. nor less than the temperature specified by the machine's manufacturer.
   vi. Chemical sanitizers used shall meet the requirements of 21 Code of Federal Regulations 178.1010.
   vii. A test kit or other device that accurately measures the parts per million concentration of the solution shall be available and used.

h. Machines using hot water for sanitizing may be used provided that wash water and pumped rinse water shall be kept clean and water shall be maintained at not less than the temperature stated in R9-8-135(A)(4)(h)(i) through (v).
   i. Single-tank, stationary-rack, dual-temperature machine:
      Wash temperature..... 150°F.
      Final rinse temperature ..... 180°F.
   ii. Single-tank, stationary-rack, single temperature machine:
      Wash temperature..... 165°F.
      Final rinse temperature ..... 165°F.
   iii. Single-tank, conveyor machine:
      Wash temperature..... 160°F.
      Final rinse temperature ..... 180°F.
   iv. Multi-tank, conveyor machine:
      Wash temperature..... 150°F.
      Pumped rinse temperature ..... 160°F.
      Final rinse temperature ..... 180°F.
   v. Single-tank, pot, pan and utensil washer (either stationary or moving rack):
      Wash temperature..... 140°F.
      Final rinse temperature ..... 180°F.

i. All dishwashing machines shall be thoroughly cleaned at least once a day or more often when necessary to maintain them in a satisfactory operating condition.

5. Drying
   a. After sanitization, all equipment and utensils shall be air dried.

B. Equipment and utensil storage
1. Handling
   a. Cleaned and sanitized equipment and utensils shall be handled in a way that protects them from contamination. Spoons, knives, and forks shall be touched only by their handles. Cups, glasses, bowls, plates and similar items shall be handled without contact with inside surfaces or surfaces that contact the user's mouth.
2. Storage
   a. Cleaned and sanitized utensils and equipment shall be stored at least 6 inches above the floor in a clean, dry location in a way that protects them from contamination by splash, dust, and other means. The food-contact surfaces of fixed equipment shall also be protected from contamination. Equipment and utensils shall not be placed under exposed sewer lines or water lines, except for automatic fire protection sprinkler heads that may be required by law.
   b. Utensils shall be air dried before being stored or shall be stored in a self-draining position.
   c. Glasses and cups shall be stored inverted. Other stored utensils shall be covered or inverted, wherever practical. Facilities for the storage of knives, forks, and spoons shall be designed and used to present the handle to the employee or consumer. Unless tableware is prewrapped, holders for knifes, forks, and spoons at self-service locations shall protect these articles from contamination and present the handle of the utensil to the consumer.
3. Single-service articles
   a. Single-service articles shall be stored at least 6 inches above the floor in closed cartons or containers which protect them from contamination and shall not be placed under exposed sewer lines or water lines, except for automatic fire protection sprinkler heads that may be required by law.
   b. Single-service articles shall be handled and dispensed in a manner that prevents contamination of surfaces which may come in contact with food or with the mouth of the user.
   c. Single-service knives, forks and spoons packaged in bulk shall be inserted into holders or be wrapped by an employee who has washed his hands immediately prior to sorting or wrapping the utensils. Unless single-service knifes, forks, and spoons are prewrapped or prepackaged, holders shall be provided to protect these items from contamination and present the handle of the utensil to the consumer.
4. Prohibited storage area
   a. The storage of food equipment, utensils, or single-service articles in toilet rooms or vestibules is prohibited.

Historical Note
Adopted effective July 10, 1979 (Supp. 79-4).

R9-8-136. Sanitary facilities and controls

A. Water supply
1. General. Enough potable water for the needs of the food service establishment shall be provided from a source constructed and operated pursuant to A.A.C. Title 18, Chapter 4, Article 2.
2. Transportation. All potable water not provided directly by pipe to the food service establishment from the source

shall be transported in a bulk water transport system and shall be delivered to a closed-water system. Both of these systems shall be constructed and operated in a manner approved by the Department Environmental Quality under A.A.C., Title 18, Chapter 4, Article 2.

3. Bottled water. Bottled and packaged potable water shall be obtained from a source that complies with A.A.C. Title 9, Chapter 8, Article 2, and shall be handled and stored in a way that protects it from contamination. Bottled and packaged potable water shall be dispensed from the original container.
4. Water under pressure at the required temperature shall be provided to all fixtures and equipment that use water.
5. Steam used in contact with food or food-contact surfaces shall be free from any materials or additives other than those specified in 21 Code of Federal Regulations 173.310.

B. Sewage. All sewage, including liquid waste, shall be disposed of by a public sewerage or by a sewage disposal system constructed and operated according to A.A.C. Title 18, Chapter 9, Article 8. Non-water-carried sewage disposal facilities are prohibited, except as permitted by R9-8-139(A)(1) through R9-8-139(A)(8) of this Article (pertaining to temporary food service establishments) or as permitted by the regulatory authority in remote areas or because of special situations.

C. Plumbing.

1. Plumbing shall be sized, installed, and maintained in accordance with the Uniform Plumbing Code. There shall be no cross-connection between the potable water supply and any nonpotable or questionable water supply nor any source of pollution through which the potable water supply might become contaminated.
2. A nonpotable water system is permitted only for purposes such as air-conditioning and fire protection and only if the system is installed in accordance with the Uniform Plumbing Code and the nonpotable water does not contact, directly or indirectly, food or utensils. The piping of any nonpotable water system shall be durably identified so that it is readily distinguishable from piping that carries potable water.
3. The potable water system shall be installed to preclude the possibility of backflow. Devices shall be installed to protect against backflow and back siphonage at all fixtures and equipment where an air gap at least twice the diameter of the water supply inlet is not provided between the water supply inlet and the fixture's flood level rim. A hose shall not be attached to a faucet unless a backflow prevention device is installed.
4. If used, grease traps shall be located to be easily accessible for cleaning.
5. If used, garbage grinders shall be installed and maintained in accordance with the Uniform Plumbing Code.
6. Except for properly trapped open sinks, there shall be no direct connection between the sewerage system and any drain originating from equipment in which food, portable equipment, or utensils are placed. When a dishwashing machine is located within 5 feet of a trapped floor drain, the dishwasher waste outlet may be connected directly on the inlet side of a properly vented floor drain trap if permitted under the Uniform Plumbing Code.

D. Toilet facilities

1. Toilet facilities shall be installed in the number and manner required by the Uniform Plumbing Code and shall be conveniently located and shall be accessible to employees at all times.
2. Toilets and urinals shall be designed to be easily cleanable.
3. Toilet rooms shall be completely enclosed and shall have tight-fitting, self-closing, solid doors, which shall be closed except during cleaning or maintenance except as approved by the Department.
4. Toilet fixtures shall be kept clean and in good repair. A supply of toilet tissue shall be provided at each toilet at all times. Easily cleanable receptacles shall be provided for waste materials. Toilet rooms used by women shall have at least one covered waste receptacle.

E. Lavatory facilities

1. Lavatory installation
   a. Lavatories shall be installed in the number and manner required by the Uniform Plumbing Code and shall be located to permit convenient use by all employees in food preparation areas and utensil washing areas.
   b. Lavatories shall be accessible to employees at all times.
   c. Lavatories shall also be located in or immediately adjacent to toilet rooms or vestibules. Sinks used for food preparation or for washing equipment or utensils shall not be used for handwashing.
2. Equipment and supplies.
   a. Each lavatory shall be provided with hot and cold water tempered by means of a mixing valve or combination faucet. Any self-closing, slow-closing, or metering faucet used shall be designed to provide a flow of water for at least 16 seconds without the need to reactivate the faucet. Steam mixing valves are prohibited.
   b. A supply of hand-cleansing soap or detergent shall be available at each lavatory. A supply of sanitary towels or a hand-drying device providing heated air shall be conveniently located near each lavatory. Common towels are prohibited. If disposable towels are used, easily cleanable waste receptacles shall be conveniently located near the handwashing facilities.
   c. Lavatories, soap dispensers, hand-drying devices and all related fixtures shall be kept clean and in good repair.

F. Garbage and refuse

1. Containers
   a. Garbage and refuse shall be kept in durable, easily cleanable, insect-proof and rodent-proof containers that do not leak and do not absorb liquids. Plastic bags and wet-strength paper bags may be used to line these containers, and they may be used for storage inside the food service establishment.
   b. Containers used in food preparation and utensil washing areas shall be kept covered after they are filled.
   c. Containers stored outside the establishment, and dumpsters, compactors and compactor systems shall be easily cleanable, shall be provided with tight-fitting lids, doors or covers, and shall be kept covered when not in actual use. In containers designed with drains, drain plugs shall be in place at all times, except during cleaning.
   d. There shall be a sufficient number of containers to hold all the garbage and refuse that accumulates.
   e. Soiled containers shall be cleaned at a frequency to prevent insect and rodent attraction. Each container shall be thoroughly cleaned on the inside and outside

in a way that does not contaminate food, equipment, utensils, or food preparation areas. Suitable facilities, including hot water and detergent or steam, shall be provided and used for washing containers. Liquid waste from compacting or cleaning operations shall be disposed of as sewage.

2. Storage
   a. Garbage and refuse on the premises shall be stored in a manner to make them inaccessible to insects and rodents. Outside storage of unprotected plastic bags or wet-strength paper bags or baled units containing garbage or refuse is prohibited. Cardboard or other packaging material not containing garbage or food wastes need not be stored in covered containers.
   b. Garbage or refuse storage rooms, if used, shall be constructed of easily cleanable, nonabsorbent, washable materials, shall be kept clean, shall be insect-proof and rodent-proof and shall be large enough to storage the garbage and refuse containers that accumulate.
   c. Outside storage areas or enclosures shall be large enough to store the garbage and refuse containers that accumulate and shall be kept clean. Garbage and refuse containers, dumpsters and compactor systems located outside shall be stored on or above a smooth surface of nonabsorbent material such as concrete or machine-laid asphalt that is kept clean and maintained in good repair.
3. Disposal
   a. Garbage and refuse shall be disposed of often enough to prevent the development of odor and the attraction of insects and rodents.
   b. Where garbage or refuse is burned on the premises it shall be done by controlled incineration that prevents the escape of particulate matter in accordance with plans and specifications approved by the Department. Areas around incineration facilities shall be clean and orderly.

G. Insect and rodent control
1. Effective measures intended to minimize the presence of rodents, flies, cockroaches, and other insects on the premises, shall be utilized. The premises shall be kept in such condition as to prevent the harborage or feeding of insects or rodents.
2. Openings to the outside shall be effectively protected against the entrance of rodents. Outside openings shall be protected against the entrance of insects by tight-fitting, self-closing doors, closed windows, screening, controlled air currents, or other means. Screen doors shall be self-closing, and screens for windows, doors, skylights, transoms, intake and exhaust air ducts, and other openings to the outside shall be tight-fitting and free of breaks. Screening material shall not be less than 16 mesh to the inch.

Historical Note
Adopted effective July 10, 1979 (Supp. 79-4). Amended effective August 6, 1990 (Supp. 90-3).

R9-8-137. Construction and maintenance of physical facilities

A. Floors
1. Floor construction
   a. Floors and floor coverings of all food preparation, food storage, and utensil-washing areas, and the floors of all walk-in refrigerating units, dressing rooms, locker rooms, toilet rooms and vestibules shall be constructed of smooth durable material such as sealed concrete, terrazzo, ceramic tiles, durable grades of linoleum or plastic, or tight wood impregnated with plastic, and shall be maintained in good repair. Nothing in this Section shall prohibit the use of antislip floor covering in areas where necessary for safety reasons.
2. Floor carpeting
   a. Carpeting, if used as a floor covering, shall be of closely woven construction, properly installed, easily cleanable, and maintained in good repair. Carpeting is prohibited in food preparation, equipment-washing and utensil-washing areas where it would be exposed to large amounts of grease and water, in food storage areas, and toilet room areas where urinals or toilet fixtures are located.
3. Prohibited floor covering
   a. The use of sawdust, wood shavings, peanut hulls, or similar material as a floor covering is prohibited.
4. Floor drains
   a. Properly installed, trapped floor drains shall be provided in floors that are water-flushed for cleaning or that receive discharges of water or other fluid waste from equipment, or in areas where pressure spray methods for cleaning equipment are used. Such floors shall be constructed only of sealed concrete, terrazzo, ceramic tile or similar materials, and shall be graded to drain.
5. Mats and duckboards
   a. Mats and duckboards shall be of nonabsorbent, grease resistant materials and of such size, design, and construction as to facilitate their being easily cleaned. Duckboards shall not be used as storage racks.
6. Floor junctures
   a. In all new or extensively remodeled establishments utilizing concrete, terrazzo, ceramic tile or similar floor materials, and where water-flush cleaning methods are used, the junctures between walls and floors shall be coved and sealed. In all other areas, the juncture between walls and floors shall not present an open seam of more than 1/32 inch.
7. Utility line installation
   a. Exposed utility service lines and pipes shall be installed in a way that does not obstruct or prevent cleaning of the floor. In all new or extensively remodeled establishments, installation of exposed horizontal utility lines and pipes on the floor is prohibited.

B. Walls and ceilings
1. Maintenance
   a. Walls and ceilings, including doors, windows, skylights, and similar closures, shall be maintained in good repair.
2. Construction
   a. The walls, including nonsupporting partitions, wall coverings, and ceilings of walk-in refrigerating units, food preparation areas, toilet rooms and vestibules shall be light colored, smooth, nonabsorbent, and easily cleanable. Concrete or pumice blocks used for interior wall construction in these locations shall be finished and sealed to provide an easily cleanable surface.
3. Exposed construction
   a. Studs, joists, and rafters shall not be exposed in walk-in refrigerating units, food preparation areas,

equipment-washing and utensil-washing areas, toilet rooms and vestibules. If exposed in other rooms or areas, they shall be finished to provide an easily cleanable surface.

4. Utility line installation
   a. Exposed utility service lines and pipes shall be installed in a way that does not obstruct or prevent cleaning of the walls and ceilings. Utility service lines and pipes shall not be unnecessarily exposed on walls or ceilings in walk-in refrigerating units, food preparation areas, equipment-washing and utensil- washing areas, toilet rooms and vestibules.
5. Attachments
   a. Light fixtures, vent covers, wall-mounted fans, decorative materials, and similar equipment attached to walls and ceilings shall be easily cleanable and shall be maintained in good repair.
6. Covering material installation
   a. Wall and ceiling covering materials shall be attached and sealed so as to be easily cleanable.

C. Cleaning physical facilities
1. General
   a. Cleaning of floors and walls, except emergency cleaning of floors, shall be done during periods when the least amount of food is exposed, such as after closing or between meals. Floors, mats, duckboards, walls, ceilings, and attached equipment and decorative materials shall be kept clean. Only dustless methods of cleaning floors and walls shall be used, such as vacuum cleaning, wet cleaning, or the use of dust-arresting sweeping compounds with brooms.
2. Utility facility
   a. In new or extensively remodeled establishments at least one utility sink or curbed cleaning facility with a floor drain shall be provided and used for the cleaning of mops or similar wet floor cleaning tools and for the disposal of mop water or similar liquid wastes. The use of lavatories, utensil-washing or equipment- washing, or food preparation sinks for this purpose is prohibited.

D. Lighting
1. General
   a. Permanently fixed artificial light sources shall be installed to provide at least 20 foot-candles of light on all food preparation surfaces and at equipment or utensil-washing work levels.
   b. Permanently fixed artificial light sources shall be installed to provide, at a distance of 30 inches from the floor:
      i. At least 20 foot-candles of light in utensil and equipment storage areas and in lavatory and toilet areas; and
      ii. At least 10 foot-candles of light in walk-in refrigerating units, dry food storage areas, and in all other areas. This shall also include dining areas during cleaning operations.
2. Protective shielding
   a. Shielding to protect against broken glass falling onto food shall be provided for all artificial lighting fixtures located over, by, or within food storage, preparation, service, and display facilities, and facilities where utensils and equipment are cleaned and stored.
   b. Infrared or other heat lamps will be protected against breakage by a shield surrounding and extending beyond the bulb, leaving only the face of the bulb exposed.

E. Ventilation
1. General
   a. All rooms shall have sufficient ventilation to keep them free of excessive heat, steam, condensation, vapors, obnoxious odors, smoke and fumes. Ventilation systems shall be installed and operated in accordance with the Uniform Mechanical Code and, when vented to the outside, shall not create an unsightly, harmful, or unlawful discharge.
2. Special ventilation
   a. Intake and exhaust air ducts shall be maintained to prevent the entrance of dust, dirt, and other contaminating materials.
   b. In new or extensively remodeled establishments, all rooms from which obnoxious odors, vapors, or fumes originate shall be mechanically vented to the outside.

F. Dressing rooms and locker areas
1. Dressing rooms and areas
   a. If employees routinely change clothes within the establishment, rooms or areas shall be designated and used for that purpose. These designated rooms or areas shall not be used for food preparation, storage or service, or for utensil washing or storage.
2. Locker areas
   a. Enough lockers or other suitable facilities shall be provided and used for the orderly storage of employee clothing and other belongings. Lockers or other suitable facilities may be located only in the designated dressing rooms or in food storage rooms or areas containing only completely packaged food or packaged single-service articles.

G. Poisonous or toxic materials
1. Materials permitted
   a. There shall be present in food service establishments only those poisonous or toxic materials necessary for maintaining the establishment, cleaning and sanitizing equipment and utensils, and controlling insects and rodents.
2. Labeling of materials
   a. Containers of poisonous or toxic materials shall be prominently and distinctly labeled and kept in their original containers with their original labels attached for easy identification of contents.
3. Storage of materials
   a. Poisonous or toxic materials consist of the following categories:
      i. Insecticides and rodenticides
      ii. Detergents, sanitizers, and related cleaning or drying agents
      iii. Caustics, acids, polishes, and other chemicals.
   b. Each of the three categories set forth in R9-8-137(G)(3)(a) shall be stored and physically located separate from each other. All poisonous or toxic materials shall be stored in cabinets or in a similar physically located separate place used for no other purpose. To preclude contamination, poisonous or toxic materials shall not be stored above food, food equipment, utensils or single-service articles, except that this requirement does not prohibit the convenient availability of detergents or sanitizers at utensil or dishwashing stations.
4. Use of materials

a. Bactericides, cleaning compounds or other compounds intended for use on food-contact surfaces shall not be used in a way that leaves a toxic residue on such surfaces or that constitutes a hazard to employees or other persons.
b. Poisonous or toxic materials shall not be used in a way that contaminates food, equipment, or utensils, nor in a way that constitutes a hazard to employees or other persons, nor in a way other than in full compliance with the manufacturer's labeling.

5. Personal medications
a. Personal medications shall not be stored in food storage, preparation or service areas.

6. First-aid supplies
a. First-aid supplies shall be stored in a way that prevents them from contaminating food and food-contact surfaces.

H. Premises
1. General
a. Food service establishments and all parts of property used in connection with their operations shall be kept free of litter.
b. The walking and driving surfaces of all exterior areas of food service establishments shall be surfaced with concrete or asphalt, or with gravel or similar material effectively treated to facilitate maintenance and minimize dust. These surfaces shall be graded to prevent pooling and shall be kept free of litter.
c. Only articles necessary for the operation and maintenance of the food service establishment shall be stored on the premises.
d. Persons whose presence is unnecessary for proper operation of food preparation and utensil-washing areas shall not be permitted in those areas.

2. Living areas
a. No operation of a food service establishment shall be conducted in any room used as living or sleeping quarters. Food service operations shall be separated from any living or sleeping quarters by complete partitioning and solid, self-closing doors.

3. Laundry facilities
a. Laundry facilities in a food service establishment shall be restricted to the washing and drying of linens, cloths, uniforms and aprons necessary to the operation. If such items are laundered on the premises, an electric or gas dryer shall be provided and used.
b. Separate rooms shall be provided for laundry facilities except that such operations may be conducted in storage rooms containing only packaged foods or packaged single-service articles.

4. Linens and clothes storage
a. Clean clothes and linens shall be stored in a clean place and protected from contamination until used.
b. Soiled clothes and linens shall be stored in nonabsorbent containers or washable laundry bags until removed for laundering.

5. Cleaning equipment storage
a. Maintenance and cleaning tools such as brooms, mops, vacuum cleaners and similar equipment shall be maintained and stored in a way that does not contaminate food, utensils, equipment, or linens and shall be stored in an orderly manner for the cleaning of that storage location.

6. Animals
a. Live animals, including birds, and turtles, shall be excluded from within the food service operational premises and from adjacent areas under the control of the permit holder. This exclusion does not apply to edible fish, crustacea, shellfish, or to fish in aquariums. Patrol dogs accompanying security or police officers, or guide dogs accompanying blind persons, shall be permitted in dining areas.

Historical Note
Adopted effective July 10, 1979 (Supp. 79-4).

R9-8-138. Mobile food units or pushcarts

A. Mobile food service
1. General
a. Mobile food units or pushcarts shall comply with the requirements of this Article applicable to food service establishments, except as otherwise provided in this Section. The regulatory authority may impose additional requirements to protect against health hazards related to the conduct of the food service establishment as a mobile operation, may prohibit the sale of some or all potentially hazardous food, and when no health hazard will result, may waive or modify requirements of this Article relating to physical facilities, except those requirements of R9-8-138(A)(4), (A)(5), (B)(1), (C)(1), and (C)(2).

2. Restricted operation
a. Mobile food units or pushcarts serving only food prepared, packaged in individual servings, transported and stored under conditions meeting the requirements of this Article, or beverages that are not potentially hazardous and are dispensed from covered urns or other protected equipment, need not comply with the requirements of this Article pertaining to the necessity of water and sewage systems nor to those requirements pertaining to the cleaning and sanitization of equipment and utensils if the required equipment for cleaning and sanitization exists at the commissary. However, frankfurters may be prepared and served from these units or pushcarts.

3. Single-service articles
a. Mobile food units or pushcarts shall provide only single-service articles for use by the consumer.

4. Water system
a. A mobile food unit requiring a water system shall have a potable water system under pressure. The system shall be of sufficient capacity to furnish enough hot and cold water for food preparation, utensil cleaning and sanitizing, and handwashing, in accordance with the requirements of this Article. The water inlet shall be located so that it will not be contaminated by waste discharge, road dust, oil, or grease, and it shall be kept capped unless being filled. The water inlet shall be provided with a transition connection of a size or type that will prevent its use for any other service. All water distribution pipes or tubing shall be constructed and installed in accordance with the requirements of this Article.

5. Waste retention
a. If liquid waste results from operation of a mobile food unit, the waste shall be stored in a permanently installed retention tank that is of at least 15 percent larger capacity than the water supply tank. Liquid waste shall not be discharged from the retention tank when the mobile food unit is in motion. All connections on the vehicle for servicing mobile food unit

waste disposal facilities shall be of a different size or type than those used for supplying potable water to the mobile food unit. The waste connection shall be located lower than the water inlet connection to preclude contamination of the potable water system.

B. Commissary
1. Base of operations
   a. Mobile food units or pushcarts shall operate from a commissary or other fixed food service establishment and shall report at least daily to such location for all supplies and for all cleaning and servicing operations.
   b. The commissary or other fixed food service establishment used as a base of operation for mobile food units or pushcarts shall be constructed and operated in compliance with the requirements of this Article.

C. Servicing area and operation
1. Servicing area
   a. A mobile food unit servicing area shall be provided and shall include at least overhead protection for any supplying, cleaning, or servicing operation. Within this servicing area, there shall be a location provided for the flushing and drainage of liquid wastes separate from the location provided for water servicing and for the loading and unloading of food and related supplies. This servicing area will not be required where only packaged food is placed on the mobile food unit or pushcart or where mobile food units do not contain waste retention tanks.
   b. The surface of the servicing area shall be constructed of a smooth nonabsorbent material, such as concrete or machine-laid asphalt and shall be maintained in good repair, kept clean, and be graded to drain.
   c. The construction of the walls and ceilings of the servicing area is exempted from the provisions of R9-8-137(B)(1) through R9-8-137(B)(6).
2. Servicing operations
   a. Potable water servicing equipment shall be installed according to A.C.R.R., Title 9, Chapter 8, Article 2 and shall be stored and handled in a way that protects the water and equipment from contamination.
   b. The mobile food unit liquid waste retention tank, where used, shall be thoroughly flushed and drained during the servicing operation. All liquid waste shall be discharged to a sanitary sewerage disposal system in accordance with R9-8-136(B)(1).

Historical Note
Adopted effective July 10, 1979 (Supp. 79-4).

R9-8-139. Temporary food service

A. Temporary food service establishments
1. General
   a. A temporary food service establishment shall comply with all requirements in this Article applicable to food service establishments, except as otherwise provided in this Section. The regulatory authority may impose additional requirements to protect against health hazards related to the conduct of the temporary food service establishment, may prohibit the sale of some or all potentially hazardous foods, and when no health hazard will result, may waive or modify requirements of this Section.
2. Restricted operations
   a. The provisions of R9-8-139(A)(2)(b) are applicable whenever a temporary food service establishment is permitted, under the provisions of R9-8-139(A)(1), to operate without complying with all the requirements of this Article applicable to food service establishments.
   b. Only those potentially hazardous foods requiring limited preparations, such as hamburgers and frankfurters that only require seasoning and cooking, shall be prepared or served. The preparation or service of other potentially hazardous foods, including pastries filled with cream or synthetic cream, custards, and similar products, and salads or sandwiches containing meat, poultry, eggs or fish is prohibited. This prohibition does not apply to any potentially hazardous food that has been prepared and packaged under conditions meeting the requirements of this Article, is obtained in individual servings, is stored at a temperature of 45°F. or below or at a temperature of 140°F. or above in facilities meeting the requirements of this Article, and is served directly in the unopened container in which it was packaged.
3. Ice
   a. Ice that is consumed or that contacts food shall be made under conditions meeting the requirements of this Article. The ice shall be obtained only in chipped, crushed, or cubed form and in single-use safe plastic or wet-strength paper bags filled and sealed at the point of manufacture. The ice shall be held in these bags until it is dispensed in a way that protects it from contamination.
4. Equipment
   a. Equipment shall be located and installed in a way that prevents food contamination and that also facilities cleaning the establishment.
   b. Food-contact surfaces of equipment shall be protected from contamination by consumers and other contaminating agents. Effective shields for such equipment shall be provided, as necessary, to prevent contamination.
5. Single-service articles
   a. All temporary food service establishments without effective facilities for cleaning and sanitizing tableware shall provide only single-service articles for use by the consumer.
6. Water
   a. Enough potable water shall be available in the establishment for food preparation, for cleaning and sanitizing utensils and equipment, and for handwashing. A heating facility capable of producing enough hot water for these purposes shall be provided on the premises.
7. Wet storage
   a. Storage of packaged food in contact with water or undrained ice is prohibited. Wrapped sandwiches shall not be stored in direct contact with ice.
8. Waste
   a. All sewage, including liquid waste, shall be disposed of according to A.C.R.R., Title 9, Chapter 8, Article 3.
9. Handwashing
   a. A convenient handwashing facility shall be available for employee handwashing. This facility shall consist of, at least, warm running water, soap, and individual paper towels.
10. Floors
   a. Floors shall be constructed of concrete, asphalt, tight wood, or other similar cleanable material kept in

good repair. Dirt or gravel, when graded to drain, may be used as subflooring when covered with clean, removable platforms or duckboards, or covered with wood chips, shavings, or other suitable materials effectively treated to control dust.

11. Walls and ceilings of food preparation areas
    a. Ceilings shall be made of wood, canvas, or other material that protects the interior of the establishment from the weather. Walls and ceilings of food preparation areas shall be constructed in a way that prevents the entrance of insects. Doors to food preparation areas shall be self-closing. Screening material used for walls, doors, or windows shall be at least 16 mesh to the inch.
    b. Counter-service openings shall not be larger than necessary for the particular operation conducted. These openings shall be provided with tight-fitting solid or screened doors or windows or shall be provided with fans installed and operated to restrict the entrance of flying insects. Counter-service openings shall be kept closed, except when in actual use.

Historical Note
Adopted effective July 10, 1979 (Supp. 79-4).

R9-8-140. Compliance procedures

A. Permits, licenses, or certificates
1. General
    a. No person shall operate a food service establishment who does not have a valid permit, license, or certificate issued to him by the regulatory authority. Only a person who complies with the requirements of this Article shall be entitled to receive or retain such a permit, license, or certificate. Permits, licenses, or certificates are not transferable. A valid permit, license, or certificate shall be posted in every food service establishment.
2. Issuance of permit, license, or certificate
    a. Any person desiring to operate a food service establishment shall make written application for a permit, license, or certificate on forms provided by the regulatory authority. Such application shall include the name and address of each applicant, the location and type of the proposed food service establishment, and the signature of each applicant.
    b. Prior to approval of an application for a permit, license, or certificate, the regulatory authority shall inspect the proposed food service establishment to determine compliance with the requirements of this Article.
    c. The regulatory authority shall issue a permit, license, or certificate to the applicant if its inspection reveals that the proposed food service establishment complies with the requirements of this Article.
    d. When an application for a permit, license, or certificate is denied by the regulatory authority, the applicant shall be entitled to a hearing before the regulatory authority in accordance with A.R.S. § 41-1013.
3. Suspension of permit, license, or certificate
    a. If the regulatory authority finds that conditions in a food service establishment present such a severe and imminent health hazard as to require emergency action and incorporates a finding to that effect in its order, summary suspension of the establishment's permit, license or certificate may be ordered pending proceedings for revocation or other action. Upon suspension pursuant to this subsection, the holder of the permit, license, or certificate may immediately move to vacate the suspension order and the regulatory authority shall hear such motion within five (5) days. In no event may a summary suspension remain in effect for more than twenty-five (25) days.
4. Revocation of permit, license, or certificate
    a. The regulatory authority may, after providing opportunity for hearing, revoke a permit, license, or certificate for serious or repeated violations of any of the requirements of this Article or for interference with the regulatory authority in the performance of duty.
    b. Prior to revocation, the regulatory authority shall notify, in writing, the holder of the permit, license, or certificate, or the person in charge of the specific reason(s) for which the permit, license, or certificate is to be revoked and that the permit, license, or certificate shall be revoked at the end of the twenty (20) days following service of such notice unless a written request for hearing is filed with the regulatory authority by the holder of the permit, license, or certificate within such twenty (20) day period. If no request for hearing is filed within the twenty (20) day period, the revocation of the permit, license, or certificate becomes final. If a request for a hearing is timely filed, the hearing shall be held within twenty (20) days of receipt of the request.
5. Service of notices
    a. A notice provided for in these regulations is properly served when it is delivered to the holder of the permit, license, or certificate, or the person in charge, or when it is sent by registered or certified mail, return receipt requested, to the last known address of the holder of the permit, license, or certificate. A copy of the notice shall be filed in the records of the regulatory authority. The notice shall comply with the provisions of A.R.S. § 41-1009(B).
6. Hearings
    a. Hearings held pursuant to the provisions of this Article shall be conducted in accordance with the requirements of A.R.S. §§ 41-1009 through 41-1013.
7. Application after revocation
    a. Whenever a revocation of a permit, license, or certificate has become final, the holder of the revoked permit, license, or certificate may make written application for a new permit, license, or certificate.

B. Inspections
1. Inspection frequency
    a. An inspection of a food service establishment shall be performed at least once every 6 months. Additional inspections of the food service establishment shall be performed as often as necessary for the enforcement of the provisions of this Article.
2. Access
    a. Representatives of the regulatory authority, after proper identification, shall be permitted to enter any food service establishment at any reasonable time for the purpose of making inspections to determine compliance with this Article. The representatives shall be permitted to examine the records of the establishment to obtain information pertaining to food and supplies purchased, received, or used.
3. Report of inspections
    a. Whenever an inspection of a food service establishment or commissary is made, the findings shall be

recorded on Form FD 2420 of the Federal Food and Drug Administration. The inspection report form shall summarize the requirements of this Article and shall set forth a weighted point value for each requirement. Inspectional remarks shall be written to reference, by Section number, the Section violated and shall state the correction to be made. The rating score of the establishment shall be one total of the weighted point values for all violations, subtracted from 100. A copy of the completed inspection report form shall be furnished to the person in charge of the establishment at the conclusion of the inspection. The completed inspection report form is a public document that shall be made available for public disclosure to any person who requests it pursuant to A.R.S. Title 39. The Director may require that completed inspection reports, or summaries thereof, be submitted to the Department on a periodic basis.

4. Correction of violations
   a. The completed inspection report form shall specify a reasonable period of time for the correction of the violations found; and correction of the violations shall be accomplished within the period specified, in accordance with the following provisions:
      i. If an imminent health hazard exists, such as complete lack of refrigeration or sewage backup into the establishment, the establishment shall immediately cease food service operations. Operations shall not be resumed until authorized by the regulatory authority.
      ii. All violations of 4- or 5-point weighted items shall be corrected as soon as possible, but in any event, within 10 days following inspection. Within 15 days after the inspection, the holder of the permit, license, or certificate shall submit a written report to the regulatory authority stating that the 4- or 5-point weighted violations may have been corrected. A follow-up inspection shall be conducted to confirm correction.
      iii. All 1- or 2-point weighted items shall be corrected as soon as possible, but in any event, by the time of the next routine inspection.
      iv. When the rating score of the establishment is less than 60, the establishment shall initiate corrective action on all identified violations within 48 hours. One or more reinspections will be conducted at reasonable time intervals to assure correction.
      v. In the case of temporary food service establishments, all violations shall be corrected within 24 hours. If violations are not corrected within 24 hours, the establishment shall immediately cease food service operations until authorized to resume by the regulatory authority.
   b. The inspection report shall state that failure to comply with any time limits for corrections may result in cessation of food service operations. An opportunity for hearing on the inspection findings or the time limitations or both will be provided if a written request is filed with the regulatory authority within twenty (20) days following the date of inspection. If a request for hearing is received, a hearing shall be held within twenty (20) days of receipt of the request, except that where the inspection report requires cessation of operations, the hearing shall be held within five (5) days of receipt of the request.
   c. Whenever a food service establishment is required under the provisions of R9-8-140(B)(4) to cease operations, it shall not resume operations until the regulatory authority determines on reinspection that conditions responsible for the order to cease operations no longer exist. Such reinspection shall be conducted within three (3) days, exclusive of weekends and holidays, of receipt of written notice from the holder of the permit, license, or certificate that the conditions responsible for the cessation order have been corrected.

C. Examination and condemnation of food
1. General
   a. Food may be examined or sampled by the regulatory authority as often as necessary for enforcement of this Article. The regulatory authority may seize, condemn, or destroy any food which is in violation of this Article or is adulterated or misbranded as defined under A.R.S. § 36-904 to 36-907. For any seizure, condemnation, or destruction of food pursuant to this Section, the regulatory authority shall follow the same procedures that the Director must follow under A.R.S. § 36-910.

D. Review of plans
1. Submission of plans
   a. Whenever a food service establishment is constructed or extensively remodeled and whenever an existing structure is converted to use as a food service establishment, properly prepared plans and specifications for such construction, remodeling, or conversion shall be submitted to the regulatory authority for review and approval before construction, remodeling or conversion is begun. The plans and specifications shall indicate the proposed layout, arrangement, mechanical plans, and construction materials of work areas, and the type and model of proposed fixed equipment and facilities. The regulatory authority shall approve the plans and specifications if they meet the requirements of this Article. No food service establishment shall be constructed, extensively remodeled, or converted except in accordance with plans and specifications approved by the regulatory authority.
2. Pre-operational inspection
   a. Whenever plans and specifications are required by R9-8-140(D)(1) to be submitted to the regulatory authority, the regulatory authority shall inspect the food service establishment prior to the start of operations, to determine compliance with the approved plans and specifications and with the requirements of this Article.

E. Procedure when infection is suspected
1. General
   a. When the regulatory authority has a reasonable cause to suspect possible disease transmission by an employee of a food service establishment, it may secure a morbidity history of the suspected employee or make any other investigation as indicated and shall take appropriate action. The regulatory authority may require any or all of the following measures:
      i. The immediate exclusion of the employee from employment in food service establishments;
      ii. The immediate closing of the food service establishment concerned until, in the opinion of

the regulatory authority, no further danger of disease outbreak exists;

iii. Restriction of the employee's services to some area of the establishment where there would be no danger of transmitting disease;

iv. Adequate medical and laboratory examination of the employee and of other employees and of his and their body discharges.

b. When the holder of a permit is ordered to take any of the measures specified in R9-8-140(E)(1)(a), he shall be entitled to a hearing before the regulatory authority in the same manner as provided in R9-8-140(B)(4)(b) for hearings on inspection report findings. Where the order requires closure of the food service establishment, reopening shall be governed by the same procedures as specified in R9-8-140(B)(4)(c).

Historical Note

Adopted effective July 10, 1979 (Supp. 79-4).

R9-8-141. Reserved

R9-8-142. Reserved

R9-8-143. Reserved

R9-8-144. Reserved

R9-8-145. Reserved

R9-8-146. Reserved

R9-8-147. Reserved

R9-8-148. Reserved

R9-8-149. Reserved

R9-8-150. Reserved

R9-8-151. Shellfish

A. Shellfish is defined for purposes of this regulation as meaning fresh or frozen oysters, clams, mussels, either shucked or in the shell.

B. No oysters, clams, or mussels shall be stored, handled, held for sale, or sold unless they have been grown, harvested, and processed in accordance with requirements of the U.S. Public Health Service Shellfish Certification Program; and unless the shipment shall have been accompanied by tag, label, or other mark showing that the shipper has been duly certified by the state, province, or country of origin, and the name and certificate number of the shipper included on the current U.S. Public Health Service list of certified shellfish shippers.

C. Shucked shellfish shall be packed without exposing them to contamination. Shucked shellfish shall be packed and shipped in clean, single-service containers made of impervious materials. Each individual package of fresh or frozen shellfish shall have permanently recorded on the package or label, so as to be easily visible, the packer's, re-packer's, or distributor's name and address, and the packer's or re-packer's certificate number preceded by the abbreviated name of the state. Containers holding one gallon or more shall have the identification on the container wall, unless the cover becomes an integral part of the container during the sealing process. Packages of frozen shellfish shall show the date or code of packing.

D. Shell stock shall be identified by a tag or label fastened to each shipping container and bearing the number of the shipper, his name and address, the kind and quantity of the shell stock in the container. The certification number shall remain with the stock until final disposition.

E. Oysters, clams, and mussels shall at all times be refrigerated at a temperature of not more than 45°F. Frozen oysters, clams, and mussels shall be held at 0°F. or lower while in the frozen condition, and may be thawed only in a refrigerator.

R9-8-152. Reserved

R9-8-153. Reserved

R9-8-154. Reserved

R9-8-155. Reserved

R9-8-156. Vending machines; sanitation ordinance and code

The sale or offering of food and beverages through a vending machine shall be in compliance with the requirements adopted by reference in R9-1-415(A).

Historical Note

Correction of reference from R9-1-415(B) to R9-1-415(A) (Supp. 83-3).

R9-8-157. Reserved

R9-8-158. Reserved

R9-8-159. Reserved

R9-8-160. Definition

"Food" is defined in R9-8-131(C), text of F.S.S.O. (1962 Edition) Section (A)(8), to mean "any raw, cooked or processed edible substance, beverage, or ingredient used or intended for use or for sale in whole or in part for human consumption." Manufactured ice is a food within that definition and for the purposes of this Article.

Historical Note

Adopted effective January 18, 1977 (Supp. 77-1).

R9-8-161. Ice manufacturing plant; sanitation

A. The premises and equipment where ice is produced, manufactured, stored, handled, or dispensed shall be kept in good repair, clean and sanitary.

B. All ice shall be produced from a safe, sanitary water supply and from an approved source.

C. All areas where ice is produced, handled, or stored shall be well lighted.

D. Clean shoes, boots, overshoes, or shoe covers shall be worn by all persons on the freezing platform or in the storage area.

E. That part of core suction or filling equipment that penetrates the ice block shall be properly protected when not in use. Where a collar is used, it shall be large enough and so positioned as to prevent the tip of the suction or filling tube from touching the deck when it is laid down.

F. Ice which has been contaminated in any manner shall not be sold, offered for sale, or given away for human consumption.

G. Ice used for human consumption shall not be cracked, chipped, crushed, packaged, or pulverized on the trucks, loading platforms, or on the ground. This operation shall be done in an enclosed, protected area.

H. All cubed or crushed ice for human consumption shall be protected from contamination at all times and shall be transported and delivered in clean, closed, single-service bags, cartons, or containers.

I. Single-service bags shall be purchased only in sanitary containers, shall be stored therein, in a clean dry place until used, and shall be handled in a sanitary manner.

R9-8-162. Ice manufacturing plant; toilet and lavatory

A. Every ice manufacturing plant shall be provided with adequate and conveniently located toilet facilities for its employees, conforming to the requirements of the Department. The doors of all toilet rooms shall be self-closing and shall not open into

any ice making area. Toilet rooms shall be kept in a clean condition, in good repair, well lighted, and ventilated to the outside air. Hand-washing signs shall be posted in each toilet room used by employees.

B. Adequate and convenient hand-washing facilities shall be provided, including hot and cold running water, soap and approved individual sanitary towels. The use of a common towel is prohibited. Lavatories in addition to those provided in toilet rooms shall be provided and shall be easily accessible to all employees. A mixing type faucet is required in new construction or when an existing plant is remodeled. No employee shall resume work after using the toilet room without first washing his hands.

R9-8-163. Ice manufacturing plant; water supply

A. Any connection or condition, including overhead leakage, that may permit an interchange of water between a public water supply and a private, industrial, or other source of water supply is prohibited unless both supplies and the method of cross-connection or condition have been approved in writing by the Department.

B. No plumbing fixture or other device which provides, or may provide, a connection between a drinking water supply and a drainage, soil, waste, or other sewer pipe so as to make possible the backflow of sewage or waste water into the water supply system shall be installed or permitted to remain installed. Water which has been used for cooling, or for any other purpose, shall not be returned to the system unless the entire installation and operation thereof has been approved in writing by the Department. All plumbing shall be installed in accordance with any local ordinance or code. Where a local ordinance or code does not exist, plumbing shall be installed in accordance with the standards adopted by reference in R9-1-412(D).

R9-8-164. Ice manufacturing plant; miscellaneous

A. Ice for human consumption shall be transported only in clean, enclosed vehicles.

B. All persons engaged in these occupations shall wear clean outer garments and shall keep their hands clean at all times while engaged in handling food, drink, utensils, or equipment. Persons while engaged in preparing or handling food shall not use tobacco in any form. Hairnets are required for female personnel; caps shall be worn by males where required.

C. The premises of all food establishments shall be kept clean and free of litter or rubbish. None of the operations connected with a food handling establishment shall be conducted in any room used for domestic purposes. Adequate lockers or dressing rooms shall be provided for employees' clothing and shall be kept clean. Soiled linens, coats, and aprons shall be kept in covered containers reserved for this purpose.

R9-8-165. Ice making and dispensing equipment

A. Ice making machines and associated equipment shall be located so that the ice will not be exposed to any source of contamination while being produced, handled, packaged or stored.

B. Beginning January 1, 1981, ice that is available for self-service by the public shall be dispensed in single-service packages or through a device which will not permit exposure or access to ice held in storage. However any new or replacement self-service ice making or dispensing equipment acquired for use after January 17, 1977, shall conform to these requirements.

C. Ice making, handling and storage equipment shall be kept clean.

D. All persons engaged in the handling or packaging of ice shall wear clean clothing and wash their hands immediately prior to such packaging.

Historical Note
Adopted effective January 18, 1977 (Supp. 77-1).

R9-8-166. Reserved

R9-8-167. Reserved

R9-8-168. Reserved

R9-8-169. Reserved

R9-8-170. Reserved

R9-8-171. Bakeries; definitions

A. A "bakery" means any place in which is carried on the process of mixing, compounding, cooking, baking, or manufacturing for sale, any bakery products.

B. "Bakery products" means any bread, biscuits, pretzels, crackers, buns, rolls, macaroni, or any similar pastes, pastries, cakes, doughnuts, pies, or other food products of which flour or meal is a principal ingredient, but does not include packaged mixes. Bakery products shall also include the materials from which the above are manufactured.

R9-8-172. Bakeries; general

A. All bakery products shall be clean, wholesome, free from spoilage, and so prepared as to be safe for human consumption.

B. Approved and effective methods of insect and vermin control shall be used at all times.

C. All persons engaged in these occupations shall wear clean outer garments and shall keep their hands clean at all times while engaged in handling food, drink, utensils, or equipment. Persons, while engaged in preparing or handling food, shall not use tobacco in any form. Hairnets are required for female personnel; caps shall be worn by males where required.

D. The premises of all establishments shall be kept clean and free of refuse. None of the operations connected with a food handling establishment shall be conducted in any room used for domestic purposes. Adequate locker or dressing rooms shall be provided for employees' clothing and shall be kept clean. Soiled linens, coats, and aprons shall be kept in containers for this purpose.

R9-8-173. Bakeries; physical plant

A. The floors of all rooms in which bakery products are stored, prepared, or sold, or in which utensils are washed, shall be of easily cleanable construction, shall be smooth, free from cracks and shall be kept clean and in good repair and, where necessary, graded to drain.

B. Walls and ceilings of rooms in which bakery products are stored or prepared shall be finished in a light color. The walls of all rooms in which bakery products are prepared, stored, or sold, or utensils washed, shall have a smooth washable surface. Walls and ceilings shall be kept clean and in good repair.

C. All openings into the outer air shall be effectively screened and doors shall be self-closing, unless other approved means are provided to control insects and vermin.

D. All rooms in which bakery products are stored, prepared, or sold, or in which utensils are washed, shall be well lighted and ventilated.

R9-8-174. Bakeries; toilet and lavatory

A. Every bakery shall be provided with adequate and conveniently located toilet facilities for its employees. The doors shall be self-closing. Toilet rooms shall be kept clean, in good repair, well lighted, and shall be ventilated to the outside air. Hand-washing signs shall be posted in each toilet room used by employees.

B. Adequate and convenient hand-washing facilities shall be provided, including hot and cold running water, soap, and

approved individual sanitary towels. The common towel is prohibited. Lavatories, in addition to those provided in toilet rooms, shall be provided and shall be easily accessible to all employees. Mixing faucets are required in new construction or when existing plant is remodeled. No employee shall resume work after using the toilet room without first washing his hands.

R9-8-175. Bakeries; water supply

A. All water shall be obtained from a safe, sanitary supply and from an approved source. Hot and cold running water shall be provided in all rooms in which products are processed, prepared, or utensils are washed.

B. Any connection or condition, including overhead leakage, that may permit an interchange of water between a public water supply and a private, industrial, or other source of water supply is prohibited unless both supplies and the method of cross-connection or condition have been approved in writing by the Department.

C. No plumbing fixture or other device which provides, or may provide, a connection between a drinking water supply and a drainage, soil, waste, or other sewer pipe so as to make possible the backflow of sewage or waste water into the water supply system shall be installed or permitted to remain installed. Water which has been used for cooling, or for any other purpose, shall not be returned to the system unless the entire installation, and operation thereof, has been approved in writing by the Department. All plumbing shall be installed in accordance with any local ordinance or code. Where a local ordinance does not exist plumbing shall be installed in accordance with the standards adopted by reference in R9-1-412(D).

R9-8-176. Bakeries; utensils and equipment

A. Utensils, show and display cases or windows, counters, shelves, tables, refrigerating equipment, sinks, troughs, cutters, mixers, and other equipment and utensils used in connection with the operation of a bakery shall be so constructed as to be easily cleaned and shall be kept in good repair. They shall be of non-toxic and corrosion-resistant material. Corners and jointings shall be smooth. New equipment shall comply with the minimum requirements of the standards adopted by reference in R9-1-415(B).

B. All equipment, including display cases or windows, counters, shelves, tables, refrigerators, stoves, hoods, and sinks shall be kept clean and free from dirt, dust, insects, and vermin and other contaminating material. All cloths used by employees shall be clean. All multi-use utensils used in the preparation of bakery products shall be thoroughly cleaned and effectively subjected to an approved bactericidal process immediately following the day's operation.

C. After washing and bactericidal treatment, utensils shall be stored in a clean dry place, protected from insects and vermin, dust, and other contamination, and shall be handled in such a manner as to prevent contamination.

Historical Note

Correction, subsection (A), reference R9-1-412(D) should read R9-1-415(B) (Supp. 83-3).

R9-8-177. Bakeries; refrigeration

All readily perishable bakery products, such as custard or cream filled pastries or pies, commonly known as cream pies, regardless of the type of filler or meringue, shall be cooled to 45°F. within one (1) hour and shall be kept at or below that temperature until final use. Perishable ingredients shall be refrigerated (45°F. or less) at all times.

R9-8-178. Bakeries; storage; display; transportation

A. All bakery products shall be so stored and displayed as to be protected from dust, insects, vermin, depredation and pollution by rodents, unnecessary handling, droplet infection, overhead leakage and other contamination. No animals or birds shall be kept or allowed in any room in which bakery products are prepared, stored, or sold, except that guide dogs, when accompanied by a blind person, may be allowed in sales or serving areas.

B. No product shall be transported or delivered unless it is wrapped or packaged to prevent airborne or manual contamination. Packaging shall be done at the place of manufacture. The only exception may be where bakery products are transported from the place of manufacture to a retail branch store where the unwrapped products shall be displayed only in enclosed display cases. The unwrapped products may be packed for transportation in dustproof bulk containers, and such containers shall be of easily cleanable construction, and shall be kept clean at all times. The unwrapped contents thereof shall not be handled by drivers or any other outside personnel.

R9-8-179. Reserved

R9-8-180. Reserved

R9-8-181. Definitions

A. "Department" means the Arizona Department of Health Services.

B. "Employee" means the permit holder, individuals having supervisory or management control or any other person working in a retail meat establishment.

C. "Equipment" means cases, counters, tables, meat blocks, knife cleats, trays, meat hooks, crossarms, refrigerators, saws, grinders, tenderizers, cleavers, and all other utensils and items used in the processing of meat.

D. "Meat" means the flesh of any animal, bird, fish or other sea food.

E. "Meat establishment" means a retail meat market, store or shop in which meat or meat products are processed, prepared, stored, or offered for sale.

F. "Utensil" means any implement used in the processing of meat.

Historical Note

Legislative enactment transferred function of meat inspection to the Livestock Sanitary Board by Laws 1973, Ch. 158. Responsibility for meat inspection returned to Department of Health Services by Laws 1977, Ch. 92, effective May 26, 1977. Amended as an emergency effective June 6, 1977 (Supp. 77-3). Emergency filings valid for 90 days pursuant to A.R.S. § 41-1003. New Section R9-8-181 adopted effective March 29, 1978 (Supp. 78-2).

R9-8-182. General

A. All meat and meat products shall be free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms and shall be considered a food as defined in R9-8-112(E).

B. Approved and effective methods of insect and vermin control shall be used at all times. Adequate rodent proofing shall be provided in buildings.

C. Meat and meat products delivered to the meat establishment in a manner which violates the rules and regulations of the Arizona Livestock Sanitary Board shall be refused by the meat establishment. Such products, if received, are subject to condemnation as provided in R9-8-116.

D. All persons working in a meat establishment shall wear clean outer garments, shall keep their hands clean and their hair

restrained at all times while engaged in handling of meat or meat products, utensils or equipment. While so engaged, such persons shall not use tobacco in any form.

E. Live animals or birds shall not be permitted on the premises of any meat establishment except that guide dogs, when accompanied by a blind person or police guard dog when accompanied by a police officer on duty, may be allowed in the sales area.

F. Handling of unpackaged meat and meat products in meat establishments, storing, processing, or selling meat and meat products by persons other than employees is prohibited.

G. No unauthorized personnel shall be allowed in areas where meat is cut, packaged, or otherwise processed.

H. Employees with infectious diseases, infected injuries or other conditions that could contribute significantly to contamination of meat and meat products shall be excluded from handling meat, meat products and utensils.

I. All meat and meat products shall be from a source approved by the Arizona Livestock Sanitary Board where it has jurisdiction. The Department reserves the right to disapprove meat or meat products from uninspected sources.

J. Meat and meat products shall not be labeled or represented in a manner which is in conflict with Livestock Sanitary Board requirements or which would misrepresent the item to the consumer.

Historical Note

Legislative enactment transferred function of meat inspection to the Livestock Sanitary Board by Laws 1973, Ch. 158. Responsibility for meat inspection returned to Department of Health Services by Laws 1977, Ch. 92, effective May 26, 1977. Amended as an emergency effective June 6, 1977 (Supp. 77-3). Emergency filings valid for 90 days pursuant to A.R.S. § 41-1003. New Section R9-8-182 adopted effective March 29, 1978 (Supp. 78-2)

R9-8-183. Physical plant

A. The floors of all meat establishments shall be constructed of impervious material where they are cleaned by flooding or are subject to spillage or other conditions of hard use. All floors shall be easily cleanable, smooth, and where necessary, graded to drain. Floor wall juncture shall be coved for easier cleaning.

B. Walls and ceilings of all rooms of a meat establishment shall be finished in a light color, and shall be smooth and washable. They shall be kept clean and in good repair.

C. The premises of all meat establishments shall be kept clean and free of refuse. No operations connected with a meat establishment shall be conducted in any room used for domestic purposes. Soiled linens, coats, and aprons shall be kept in containers reserved for this purpose. An adequate area for employees' clothing shall be provided.

D. The use of sawdust or other similar materials on the floor of meat cutting rooms or meat storage areas may be permitted where in the opinion of the Department it does not constitute or create a health hazard. Sawdust or similar materials shall be clean and free of extraneous or deleterious substances and shall be removed and discarded at the end of each day's business.

E. All openings into the outer air shall be effectively screened. Doors shall be self-closing unless other effective methods are provided to control insects and vermin.

F. All rooms of a meat establishment shall be well lighted and well ventilated, except that walk-in refrigerators or storage boxes may not need ventilation where recirculation of air is provided.

Historical Note

Legislative enactment transferred function of meat inspection to the Livestock Sanitary Board by Laws 1973, Ch. 158. Responsibility for meat inspection returned to Department of Health Services by Laws 1977, Ch. 92, effective May 26, 1977. Amended as an emergency effective June 6, 1977 (Supp. 77-3). Emergency filings valid for 90 days pursuant to A.R.S. § 41-1003. New Section R9-8-183 adopted effective March 29, 1978 (Supp. 78-2)

R9-8-184. Toilet and lavatory

A. Adequate and convenient toilet facilities shall be provided for employees, and shall conform to the requirements of the Department. The doors of all toilet rooms shall be self-closing. Toilet rooms shall be kept clean, in good repair, well lighted, and ventilated to the outside air. Handwashing signs shall be posted in each toilet room used by employees.

B. Adequate and convenient handwashing facilities shall be provided, including hot and cold running water, soap, and individual sanitary towels. Lavatories, in addition to those provided in toilet rooms, shall be provided in all processing rooms and shall be easily accessible to all employees. Mixing faucets are required in new constructions or when the existing plant is remodeled. No employee shall resume work after using the toilet or performing a task which might contaminate his hands without first thoroughly washing his hands. Lavatories and wash rooms shall be kept clean and sanitary.

Historical Note

Legislative enactment transferred function of meat inspection to the Livestock Sanitary Board by Laws 1973, Ch. 158. Responsibility for meat inspection returned to Department of Health Services by Laws 1977, Ch. 92, effective May 26, 1977. Amended as an emergency effective June 6, 1977 (Supp. 77-3). Emergency filings valid for 90 days pursuant to A.R.S. § 41-1003. New Section R9-8-184 adopted effective March 29, 1978 (Supp. 78-2).

R9-8-185. Water supply

A. All water shall be obtained from a public or semi-public water system approved by the Department under Arizona Compilation of Rules and Regulations Title 9, Chapter 8, Article 2. Hot and cold running water shall be easily accessible to all rooms in which products are processed, prepared, or in which utensils are washed.

B. Any connection or condition, including overhead leakage, that may permit an interchange of water between a public or semi-public water supply and a private, industrial, or other source of water supply, is prohibited.

C. No plumbing fixture of other device which provides, or may provide, a connection between a public or semi-public water supply and a drainage, soil, waste, or other sewer pipe so as to make possible the backflow or back-siphonage of sewage or waste water into the water supply system shall be installed or permitted to be installed. Water which has been used for cooling, or for any other purpose, shall not be returned to the system unless the entire installation and operation thereof has been approved in writing by the Department. All plumbing shall be installed in accordance with the applicable local ordinance or code. Where a local ordinance does not exist, plumbing shall be installed in accordance with the requirements adopted by reference in R9-1-412(D).

Historical Note

Legislative enactment transferred function of meat inspection to the Livestock Sanitary Board by Laws

1973, Ch. 158. Responsibility for meat inspection returned to Department of Health Services by Laws 1977, Ch. 92, effective May 26, 1977. Amended as an emergency effective June 6, 1977 (Supp. 77-3). Emergency filings valid for 90 days pursuant to A.R.S. § 41-1003. New Section R9-8-185 adopted effective March 29, 1978 (Supp. 78-2).

R9-8-186. Utensils and equipment

A. All equipment shall be so constructed as to be easily cleaned, and shall be kept in good repair and shall be nontoxic and of corrosion resistant material. Utensils containing or plated with cadmium are prohibited.

B. All equipment and utensils shall be kept clean and free from dust, dirt, insects, vermin, and other contaminating material. After each use equipment and utensils shall first be rinsed with hot water to remove the gross food particles. They shall be washed thoroughly with a suitable detergent, rinsed with clean water, and then sanitized in conformance with these regulations. When a chemical sanitizer is used, it shall consist of a solution of a chlorine compound providing, in use solution, at least 100 parts per million of free chlorine. Other methods of sanitizing may be used when approved by the Department.

C. Equipment must be thoroughly cleaned and sanitized after cutting poultry prior to processing any other products.

D. Grinders must be thoroughly cleaned and sanitized after cutting pork prior to processing any other products.

E. Grinding heads shall be washed and sanitized at least once a day. Grinding heads which are easily removable shall be washed and sanitized once a day when in use, and shall be stored at 45°F. or less when not in use.

F. A sink having at least two compartments connected with hot and cold water under pressure shall be provided for the washing and bactericidal treatment of equipment and utensils used in meat establishments. Meat establishments constructed or remodeled after the effective date of these regulations must have a sink for these purposes with at least three compartments. The size of each compartment shall be determined by the largest piece of equipment that needs to be washed. The sink drains are to be connected to a sewage disposal system approved by the Department under Arizona Compilation of Rules and Regulations Title 9, Chapter 8, Article 3.

Historical Note

Legislative enactment transferred function of meat inspection to the Livestock Sanitary Board by Laws 1973, Ch. 158. Responsibility for meat inspection returned to Department of Health Services by Laws 1977, Ch. 92, effective May 26, 1977. Amended as an emergency effective June 6, 1977 (Supp. 77-3). Emergency filings valid for 90 days pursuant to A.R.S. § 41-1003. New Section R9-8-186 adopted effective March 29, 1978 (Supp. 78-2).

R9-8-187. Refrigeration; packaging; transportation

A. The temperature of meat, meat products, and other products requiring refrigeration shall not exceed 45°F. at any time. Frozen products shall be maintained at a temperature of not more than 0°F.

B. All refrigerators, walk-in boxes, showcases, freezers and vehicles must be equipped with properly located, easily readable thermometers which are accurate within ±2°F.

C. Meat and meat products shall be packaged before delivery in containers or wrappings which assure the product will be protected from contamination.

D. All trucks used for the delivery of meat or meat products to a retail meat establishment shall be completely enclosed and shall be refrigerated so that the temperature of the products being transported shall not rise above 45°F. at any time. In an emergency, meat or meat products may temporarily be delivered in an unrefrigerated truck provided delivery can be made in an hour or less, but in no case will delivery be made in an unrefrigerated truck when a refrigerated truck can be obtained. All meat and meat products shall be transported in such trucks and in such a manner as not to expose the meat or meat products to dust, dirt, filth, or other deleterious substance. No meat or meat products shall be laid directly on the floor of any truck.

Historical Note

Legislative enactment transferred function of meat inspection to the Livestock Sanitary Board by Laws 1973, Ch. 158. Responsibility for meat inspection returned to Department of Health Services by Laws 1977, Ch. 92, effective May 26, 1977. Amended as an emergency effective June 6, 1977 (Supp. 77-3). Emergency filings valid for 90 days pursuant to A.R.S. § 41-1003. New Section R9-8-187 adopted effective March 29, 1978 (Supp. 78-2)

R9-8-188. Processed meat and meat food product requirements for retail meat establishments

A. Miscellaneous raw beef products

1. Chopped beef, ground beef. “Chopped beef” or “ground beef” shall consist of chopped fresh and/or frozen beef with or without seasoning and without the addition of beef fat as such, shall not contain more than 30 percent fat, and shall not contain added water, binders, or extenders. When beef cheek meat (trimmed beef cheeks) is used in the preparation of chopped or ground beef, the amount of such cheek meat shall be limited to 25 percent, and if in excess of natural proportions, its presence shall be declared on the label in the ingredient statement, and contiguous to the name of the product.
2. Hamburger. “Hamburger” shall consist of chopped fresh and/or frozen beef with or without the addition of beef fat as such and/or seasoning, shall not contain more than 30 percent fat, and shall not contain added water, binders, or extenders. Beef cheek meat (trimmed beef cheeks) may be used in the preparation of hamburger only in accordance with the conditions prescribed in paragraph (1) of this subsection.
3. Beef patties. “Beef patties” shall consist of chopped fresh and/or frozen beef with or without the addition of beef fat as such and/or seasonings. Binders or extenders and/or partially defatted beef fatty tissue may be used without added water or with added water only in amounts such that the product's characteristics are essentially that of a meat patty. These products must have an ingredient statement with all products used in order of predominance as in subsection (F).
4. Fabricated steak. Fabricated beef steaks, veal steaks, beef and veal steaks, or veal and beef steaks, and similar products, such as those labeled “Beef Steak, Chopped, Shaped, Frozen”, “Minute Steak, Formed, Wafer Sliced, Frozen”. “Veal Steaks, Beef added, Chopped-Molded-Cubed-Frozen, Hydrolyzed Plant Protein, and Flavoring” shall be prepared by comminuting and forming the product from fresh and/or frozen meat, with or without added fat, of the species indicated on the label. Such products shall not contain more than 30 percent fat and shall not contain added water, binders or extenders. Beef cheek meat (trimmed beef cheeks) may be used in the preparation of fabricated beef steaks only in accordance with the conditions prescribed in paragraph (1) of this subsection.

B. Fresh pork sausage. "Fresh pork sausage" is sausage prepared with fresh pork or frozen pork, or both, not including pork by-products, and may be seasoned with condimental substances. It shall not be made with any lot of product which, in the aggregate, contains more than 50 percent trimmable fat, that is fat which can be removed by thorough, practicable trimming and sorting. To facilitate chopping or mixing, water or ice may be used in an amount not to exceed 3 percent of the total ingredients used.

C. Chorizo. Pork must be treated to destroy trichinae or use certified pork. If total added moisture is more than 3 percent the product must be labeled "Imitation".

D. Fresh beef sausage. "Fresh beef sausage" is sausage prepared with fresh beef or frozen beef, or both, not including beef by-products, and may be seasoned with condimental substances. The finished products shall not contain more than 30 percent fat. To facilitate chopping or mixing, water or ice may be used in an amount not to exceed 3 percent of the total ingredients used.

E. Breakfast sausage. "Breakfast sausage" is sausage prepared with fresh and/or frozen meat, or meat and meat by-products and may be seasoned with condimental substances. It shall not be made with any lot of products which, in the aggregate, contains more than 50 percent fat which can be removed by thorough practicable trimming and sorting. To facilitate chopping or mixing, water or ice may be used in an amount not to exceed 3 percent of the total ingredients used. Extenders or binders are limited to 3 1/2 percent of the finished sausage.

F. Pork products. All products with pork as an ingredient, except those customarily well cooked in the home, must be treated for the control of trichinae. These products include all cooked and smoked sausage and pork products that may appear to be cooked. The treatment consists of heating to a minimum internal temperature of 137°F., or freezing as set forth in the following chart.

Temperatures °F.	Packages or pieces not over 6" in thickness Group 1 (days)	Not over 27" in thickness Group 2 (days)
5	20	30
-10	10	20
-20	6	12

G. Cooked sausage. Frankfurter, frank, furter, hotdog, wiener, vienna, bologna, garlic bologna, knockwurst and similar products.

1. Frankfurter, frank, furter, hotdog, wiener, vienna, bologna, garlic bologna, knockwurst and similar cooked sausages are comminuted, semi-solid sausages prepared from one or more kinds of raw skeletal muscle meat or raw skeletal muscle and raw or cooked poultry meat, and seasoned and cured, using one or more curing agents. They may or may not be smoked. The finished products shall not contain more than 30 percent fat. Water or ice, or both, may be used to facilitate chopping or mixing, or to dissolve the curing ingredients, but the sausage shall not contain more than 10 percent of added water. These sausage products may contain uncooked, cured pork from primal parts which do not contain any phosphates. Such products may contain raw or cooked poultry meat not in excess of 15 percent of the total ingredients, excluding water, in the sausage. Such poultry meat ingredients shall be designated in the ingredient statement on the label of such sausage.
2. Frankfurter, frank, furter, hotdog, wiener, vienna, bologna, garlic bologna, knockwurst and similar cooked sausages that are labeled with the phrase "with by-products" or "with variety meats" in the product name are comminuted, semi-solid sausages consisting of not less than 15 percent of one or more kinds of raw skeletal muscle meat with raw meat by-products, or not less than 15 percent of one or more kinds of raw skeletal muscle meat with raw meat by-products and raw or cooked poultry products; and seasoned and cured. They may or may not be smoked. Partially defatted pork fatty tissue or partially defatted beef fatty tissue, or a combination of both, may be used in an amount not exceeding 15 percent of the meat and meat by-products or meat, meat by-products, and poultry products ingredients. The finished products shall not contain more than 30 percent fat. Water or ice, or both, may be used to facilitate chopping or mixing or to dissolve the curing and seasoning ingredients, but the sausage shall contain no more than 10 percent of added water. These sausage products may contain uncooked, cured pork which does not contain any phosphates or contain only approved phosphates. These sausage products may contain poultry products, individually or in combination, not in excess of 15 percent of the total ingredients, excluding water, in the sausage. Such poultry products shall not contain kidneys or sex glands. The amount of poultry skin present in the sausage must not exceed the natural proportion of skin present on the whole carcass of the kind of poultry used in the sausage. The poultry products used in the sausage shall be designated in the ingredient statement on the label of such sausage. Meat by-products used in the sausage shall be designated individually in the ingredient statement on the label for such sausage.
3. A cooked sausage as defined in paragraph (1) of this subsection shall be labeled by its generic name, e.g., frankfurter, frank, furter, hotdog, wiener, vienna, bologna, garlic bologna, or knockwurst. Sausage products within paragraph (1) that are prepared with meat from a single species of cattle, sheep, swine, or goats shall be labeled with the term designated the particular species in conjunction with the generic name, e.g., "Beef frankfurter".
4. A cooked sausage as defined in paragraph (2) of this subsection shall be labeled by its generic name, e.g., frankfurter, frank, furter, hotdog, wiener, vienna, bologna, garlic bologna, or knockwurst, in conjunction with the phrase "with by-products" or "with variety meats" with such supplemental phrase shown in a prominent manner directly contiguous to the generic name and in the same color on an identical background.
5. With appropriate labeling such as "Frankfurter, Calcium Reduced Dried Skim Milk Added", one or more of the following binders may be used in cooked sausage otherwise complying with paragraphs (1) and (2) of this subsection: Dried milk, calcium reduced dried skim milk, nonfat dry milk, cereal, vegetable starch, starchy vegetable flour, soy flour, soy protein concentrate and isolated soy protein, provided such ingredients, individually or collectively, do not exceed 3 1/2 percent of the finished product, except that 2 percent of isolated soy protein shall be deemed to be the equivalent of 3 1/2 percent of any one or more of the other binders.
6. Cooked sausages shall not be labeled with terms such as "All Meat" or "All (species)", or otherwise to indicate they do not contain nonmeat ingredients or are prepared only from meat. Sodium nitrate, sodium nitrite, potassium nitrate and potassium nitrite may be added to the product provided that total nitrates and nitrites are not in excess of 200 parts per million. Bacon shall not contain nitrates and nitrites in excess of 120 parts per million.

Seasoning substances or additives including common salt, wood smoke, vinegar, flavorings, spices, or approved sugars, such as sucrose, can or beef sugar, maple sugar, dextrose, invert sugar, honey, corn syrup solids, corn syrup and glucose syrup may be added.

H. Labeling. All processed, blended or otherwise prepared meat or meat food products which are packed in any can, pot, tin, box, canvas or other receptacle or covering constituting an immediate or true container, shall be labeled. Labels shall contain, prominently and informatively, the following:

1. The true name of the product, identified with the manufacturer and place of manufacture.
2. A list of the ingredients giving common or usual names of the ingredients, when there are two or more ingredients, and arranged in the order of their predominance. If ice or water is used to facilitate chopping or mixing in the preparation of sausage, it must be appropriately declared on the label.

Historical Note

Legislative enactment transferred function of meat inspection to the Livestock Sanitary Board by Laws 1973, Ch. 158. Responsibility for meat inspection returned to Department of Health Services by Laws 1977, Ch. 92, effective May 26, 1977. Amended as an emergency effective June 6, 1977 (Supp. 77-3). Emergency filings valid for 90 days pursuant to A.R.S. § 41-1003. New Section R9-8-188 adopted effective March 29, 1978 (Supp. 78-2).

R9-8-189. Inspections

Inspections of meat establishments will be performed by the Department at least once every six months. Additional inspections of meat establishments may be performed as often as necessary for the enforcement of these rules.

Historical Note

Adopted effective March 29, 1978 (Supp. 78-2).

R9-8-190. Reserved

R9-8-191. Repealed

Historical Note

Repealed effective August 6, 1990 (Supp. 90-3).

ARTICLE 2. BOTTLED WATER

R9-8-201. Definitions

In this Article, unless the context otherwise requires:

1. "Approved source", when used in reference to a plant's water product or water used in the plant's operations, means the source of the water and the water therefrom, whether it be from a spring, artesian well, drilled well, municipal water supply or any other source that has been inspected by the Arizona Department of Environmental Quality and issued a certificate or notification of approval.
2. "Artesian well water" means natural water from a well tapping an aquifer in which the water level will stand above the bottom of the confining bed of the aquifer and in which the hydraulic pressure of the water in the aquifer is greater than the force of gravity.
3. "Bottled water" means water that is from an approved source and is placed by a food establishment in a sealed container or package for human consumption or other consumer uses and has been produced by any of the processes described in R9-8-203 or which has undergone minimum treatment consisting of filtration (activated carbon and/or particulate) and ozonation or an equivalent process.
4. "Carbonated water" means bottled water containing carbon dioxide. It is also known as "sparkling water" or "soda water".
5. "Cleaning-in-place" means the automatic or mechanical cleaning and/or sanitizing of a stationary piece of equipment.
6. "CFR" means the Code of Federal Regulations.
7. "Department" means the Arizona Department of Health Services or a local health department designated by the Director.
8. "Distilled water" means water which has been produced by a process of distillation and meets the definition of purified water on page 1124 of The United States Pharmacopeia (21st rev.) dated 1985, Mack Publishing Company, Easton, Pennsylvania 18042, incorporated herein by reference and on file with the Office of the Secretary of State.
9. "Drinking water" means water obtained from an approved source for purposes of human consumption.
10. "Filler equipment" means a machine used for the purpose of bottling or packaging liquids.
11. "Fluoridated water" means water containing naturally occurring or added fluoride of not less than 0.8 milligram per liter fluoride ion and complying with the Food and Drug Administration quality standards set forth in 21 CFR 103.35(d)(2) (4-1-89 Ed.), incorporated herein by reference and on file with the Office of the Secretary of State.
12. "Mineral water" means "natural water" that contains not less than 500 parts per million dissolved mineral solids and whose source is approved by the Department of Environmental Quality.
13. "Mineralized water" means water which has been modified by mineral addition or deletion and contains not less than 500 parts per million dissolved mineral solids and whose source is approved by the Department of Environmental Quality.
14. "Natural water" means spring, artesian well or well water, derived from an underground formation, which is unmodified by blending with water from another source or by mineral addition or deletion but may be treated to reduce the concentration of any substance, except minerals, to meet the safe drinking water standards established by the Arizona Department of Environmental Quality.
15. "Naturally carbonated" or "naturally sparkling" means water than contains carbon dioxide and that emerges from the source and is bottled directly with its entrapped gas or from which the gas is mechanically separated from the water and later reintroduced into the water at the time of bottling.
16. "Purified water" means water produced by distillation, deionization or reverse osmosis and meets the definition of purified water on page 1124 in The United States Pharmacopeia (21st rev.) dated 1985, Mack Publishing Company, Easton, Pennsylvania 18042, incorporated herein by reference and on file with the Office of the Secretary of State.

17 "Soda water" means bottled water containing carbon dioxide.

18. "Sparkling water" means bottled water containing carbon dioxide.
19. "Spring water" means water other than artesian that is derived from a natural underground stratum that flows naturally or by external enhancement to the surface

through a natural orifice or from a bore hole adjacent to the natural orifice and which meets the requirements of "natural water".

20. "Well water" means water from a hole bored into the ground which taps the water of the aquifer and which meets the requirements of "natural water".

Historical Note
Adopted effective August 6, 1990 (Supp. 90-3).

R9-8-202. Water quality and source

A. All bottled water processed in Arizona shall be obtained from a source whose quality is approved by the Director of the Department of Environmental Quality in accordance with the provisions of the A.A.C. Title 18, Chapter 4, Article 2.

B. With the exception of mineral water, mineralized water and carbonated water, bottled water processed or sold in Arizona shall meet or exceed the minimum quality standards prescribed by 21 CFR 103.35 (4-1-89 Ed.), incorporated herein by reference and on file with the Office of the Secretary of State.

Historical Note
Adopted effective August 6, 1990 (Supp. 90-3).

R9-8-203. Processing practices

A. All bottled water processed or sold in Arizona shall be processed and packaged in accordance with the U.S. Food and Drug Administration's Good Manufacturing Practice regulations for bottled water beginning at 21 CFR 129 (4-1-89 Ed.), incorporated herein by reference and on file with the Office of the Secretary of State.

B. Bottled water shall not be processed or bottled through a line or other equipment used for any other purpose, except that filler equipment used to bottle liquids intended for human consumption may also be used to bottle water, provided:

1. Filler and processing equipment, unless specifically designed for cleaning-in-place, shall be completely disassembled and cleaned after each use and sterilized after assembly.
2. A separate set of gaskets, O-rings and similar flexible material is used for bottling water.
3. A physical break exists between all processing lines at the filler inlet.

C. The provisions of R9-8-203(B) shall not apply to soft drink bottling operations processing carbonated water.

Historical Note
Adopted effective August 6, 1990 (Supp. 90-3).

R9-8-204. Labeling requirements

A. All bottled water processed or sold in Arizona shall conform to the requirements established in A.R.S. § 36-906 and shall be labeled in compliance with one of the following standards:

1. Mineral water shall be labeled "mineral water" or "natural mineral water".
2. Mineralized water shall be labeled "mineralized water".
3. Spring water shall be labeled "spring water" or "natural spring water".
4. Naturally carbonated or naturally sparkling water shall be labeled with the words "naturally carbonated" or "naturally sparkling".
5. Bottled water which contains carbon dioxide, other than "naturally carbonated or naturally sparkling", shall be labeled with the words "carbonated" or "sparkling" or "soda water".
6. Well water shall be labeled "well water" or "natural well water".
7. Artesian well water shall be labeled "Artesian well water", "natural artesian well water" or "natural well water."
8. Purified water shall be labeled "purified water" and the method of preparation shall be stated on the label except that purified water produced by distillation may be labeled "distilled water".
9. Drinking water shall be labeled "drinking water".

B. Any bottler, distributor, or vendor of bottled water whose corporate name, brand name or trademark contains the words "well", "artesian well", "natural" or any derivation of these words shall label each bottle with the source of the water in typeface at least equal to the size of the typeface of the corporate name or trademark if the actual source of the bottled water is different from the source stated in the corporate name, brand name or trademark.

C. The use of words "spring", "spring fresh", "spring brand", "spring type" or other language containing the word "spring" in a corporate name, brand name or trademark, or in describing water, is prohibited unless the water is "spring water" as defined in R9-8-201.

D. Supplemental printed information and graphics concerning recognized uses of the water may appear on the label but shall not imply properties of the product or preparation methods which are not accurate.

Historical Note
Adopted effective August 6, 1990 (Supp. 90-3).

R9-8-205. Source water sampling

A. Samples shall be taken of approved sources of water by plant operators or their agents according to the schedule established in A.A.C. R18-4-223.

B. Sampling and analyses shall be by laboratories certified in accordance with A.A.C. R9-14-602 and shall be in addition to any sampling performed by the Department.

C. Original laboratory records of bacteriological analyses shall be kept by the bottler for five years. Records of chemical analyses shall be kept ten years.

Historical Note
Adopted effective August 6, 1990 (Supp. 90-3).

R9-8-206. Finished product sampling

A. To assure that the plant's production of bottled water is in compliance with 21 CFR 103.35 (4-1-89 Ed.), incorporated herein by reference and on file with the Office of the Secretary of State, the plant shall have the following analyses performed by a laboratory certified according to the provisions of A.A.C. R9-14-602:

1. A representative sample from a batch or segment of a continuous production for each type of bottled water produced by the plant shall be analyzed weekly for microbiological purposes.
2. A representative sample from a batch or segment of a continuous production for each type of bottled water produced by the plant shall be analyzed annually for chemical, physical and radiological compliance.

B. The representative samples required in subsection (A) above shall be derived from the bottled product.

C. Records of the sampling and analyses shall be maintained on file at the place of operation for a period of two years and shall be made readily available to the Director.

Historical Note
Adopted effective August 6, 1990 (Supp. 90-3).

R9-8-207. Transportation vehicles

A. Bottled water shall be transported in vehicles used only for the transportation of food and other non-toxic products.

B. All vehicles transporting bottled water shall be clean and shall protect the bottled water from dust, dirt, insects and other vermin.

Historical Note

Adopted effective August 6, 1990 (Supp. 90-3).

R9-8-208. Certification and inspection

A. Upon application by an establishment, pursuant to R9-8-119, a bottled water processing certificate shall be issued prior to the establishment's operation and shall be valid for a period of one year. An establishment shall apply for renewal of its certificate no later than 60 days prior to its expiration.

B. A bottled water processing certificate shall be issued when the bottler has complied with all provisions of this Article and has in its possession a certificate form the Department of Environmental Quality approving the water source.

C. All bottled water processors shall be inspected prior to licensure and once every six months thereafter for compliance with the minimum standards of this Article.

Historical Note

Adopted effective August 6, 1990 (Supp. 90-3).

R9-8-209. Public nuisance

A. Any water supply, label, premises, equipment, process or vehicle which does not comply with the minimum standards of this Article shall be considered a public nuisance.

B. All bottled water public nuisances shall be abated by revocation of the bottling establishment's permit or through the procedures established in A.R.S. § 36-601 or by any other means permissible by law.

Historical Note

Adopted effective August 6, 1990 (Supp. 90-3).

ARTICLE 3. PUBLIC TOILET FACILITIES

Editor's Note: Former Article 3 renumbered to Title 18, Chapter 9, Article 8 (Supp. 87-3).

R9-8-301. Definitions

In this Article:

1. "Bathroom" means a restroom that contains a shower or bathtub.
2. "Department" means the Department of Health Services.
3. "Director" means the Director of the Department of Health Services.
4. "Flooded" means a sanitary fixture that is overflowing sewage or filled with sewage to the point of overflowing.
5. "Lavatory" means a sink or basin for cleansing hands.
6. "Person" means a governmental agency, individual, organization, association, partnership, business, corporation, or company.
7. "Plumbing system" means sanitary fixtures, pipes, and related parts assembled to carry water into a structure and carry sewage out of a structure.
8. "Portable toilet" means a transportable toilet connected to a leakproof tank to receive and store sewage temporarily.
9. "Potable" means water obtained from a source or distribution system that complies with the requirements of the Department of Environmental Quality as provided in 18 A.A.C. 4.
10. "Putrescible waste" means a solid or semisolid waste material that is likely to decompose, decay, spoil, rot, or provide food for insects, rodents, birds, or other pests.
11. "Refuse" means putrescible and nonputrescible solid and semisolid waste, including trash, garbage, or rubbish.
12. "Restroom" means a structure or room containing a lavatory and toilet, or lavatory, toilet, and urinal, available to a guest or customer of a business or governmental agency, and unconnected to dwelling or sleeping quarters.
13. "Sanitary fixture" means a bathtub, floor drain, lavatory, shower, toilet, or urinal connected to a plumbing system.
14. "Sewage" means the liquid waste contained in a sanitary fixture or sanitary fixture drain pipe or any liquid containing putrescible particles, feces, or urine.
15. "Special event" means a group of 100 or more individuals gathered together in lawful assembly for 4 or more hours in an outdoor area that does not have restroom or bathroom facilities.
16. "Urinal" means an upright basin used by males for urination only.

Historical Note

Adopted effective April 10, 1997 (Supp. 97-2).

R9-8-302. Persons Responsible

An owner of a bathroom, restroom, or portable toilet, or a person who administers a special event, shall comply with the provisions of this Article.

Historical Note

Adopted effective April 10, 1997 (Supp. 97-2).

R9-8-303. Constructing and Maintaining a Restroom or Bathroom

A. A restroom or plumbing system shall be installed and maintained according to the standards contained in A.A.C. R9-1-412(A)(3), the "Uniform Plumbing Code."

B. Ventilation in a restroom or bathroom shall be provided according to the standards contained in A.A.C. R9-1-412(A)(1), the "Uniform Building Code."

C. An interior floor, wall, ceiling, and the attached accessories in a restroom shall be kept clean, dry, and free of mold, holes, chips, cracks, or flaking. An interior restroom floor and wall joint shall be finished with a smooth sealant or trimmed with a wall base trim strip.

D. An interior floor, wall, ceiling, and the attached accessories in a bathroom shall be finished with a smooth, waterproof, and washable surface. An interior bathroom floor and wall joint shall be waterproof.

E. A bathroom or restroom shall be provided with:
1. Soap that is dispensed from a soap dispenser,
2. A heated air blower or paper towels from a paper towel dispenser, and
3. A constant supply of toilet paper from a toilet paper dispenser in each toilet.

F. If a pressurized spray cleaning method is used in a bathroom or restroom:
1. A floor drain shall be built into the floor and the floor shall be sloped to the floor drain to promote drainage, and
2. The interior floor and wall joints shall be waterproof.

G. The following conditions in a bathroom or restroom are prohibited:
1. An open window without an insect screen,
2. A sanitary fixture without potable water under pressure,
3. A plumbing system leak,
4. A dirty sanitary fixture, and
5. A flooded sanitary fixture.

Historical Note

Adopted effective April 10, 1997 (Supp. 97-2).

R9-8-304. Constructing and Maintaining a Portable Toilet

A portable toilet shall be built and maintained to include:

1. A sewage storage tank, toilet seat, toilet, and urinal made of durable, smooth, leakproof, and rustproof materials;
2. Waterproof and durable floor, wall, ceiling, and door materials;
3. A vent pipe 3 inches in diameter connected to the sewage storage tank and extending 6 inches above the roof of the toilet enclosure; and
4. A constant supply of toilet paper from a toilet paper dispenser.

Historical Note

Adopted effective April 10, 1997 (Supp. 97-2).

R9-8-305. Common Bath Towel Prohibited

A cloth towel provided by a business for a guest or customer to use at the business shall be machine washed with detergent and machine dried before the cloth towel is issued to another guest or customer.

Historical Note

Adopted effective April 10, 1997 (Supp. 97-2).

R9-8-306. Special Events

A. Portable toilets and refuse containers shall be deployed at a special event as follows:
1. One portable toilet for the 1st 100 people, and 1 portable toilet for each additional 100 people, or portion thereof;
2. One refuse container for the 1st 100 people, and 1 refuse container for each additional 100 people, or portion thereof; and
3. Within 200 feet of the special event place.

B. Sewage and refuse generated at a special event shall be collected and disposed of under R9-8-307(A), (B), (C), and (E).

Historical Note

Adopted effective April 10, 1997 (Supp. 97-2).

R9-8-307. Disposal of Sewage and Refuse

A. The collection, storage, and treatment of sewage and refuse shall comply with the requirements of the Department of Environmental Quality under:
1. 18 A.A.C. 8, Article 6, and 18 A.A.C. 9, Articles 7 and 8, for sewage; and
2. 18 A.A.C. 8, Article 5, for refuse.

B. A disposable refuse bag shall be used to store refuse generated at a special event. A full refuse bag shall be tied closed before disposal in accordance with subsection (A).

C. A refuse container in a bathroom or restroom, or at a special event, shall be free of accumulations of putrescible waste.

D. A bathroom or restroom exclusively for female use, or a combination male-and-female use restroom shall be provided with a refuse container with a matching lid.

E. An overflowing refuse container in a bathroom or restroom, or at a special event, is prohibited.

Historical Note

Adopted effective April 10, 1997 (Supp. 97-2).

R9-8-308. Inspection and Enforcement

A. An owner of a restroom, bathroom, or portable toilet, or a person who administers a special event, shall allow an inspector from the state or local health department to enter into and inspect the premises for compliance with this Article. An inspector from the state or local heath department shall display a state or local agency identification credential before conducting an inspection.

B. If an inspector finds a violation of this Article, the inspector may issue a notice of violation to the owner of a bathroom, restroom, or portable toilet, or the administrator of a special event. A notice of violation shall specifically state the nature of the violation and allow a reasonable time for the violation to be corrected.

C. If the Director has reasonable cause to believe that a person is operating a bathroom, restroom, portable toilet, or special event in violation of this Article, the Director shall order the closure of the bathroom, restroom, portable toilet, or special event by issuing a cease and desist order under A.R.S. § 36-601. Violations of this Article may also be corrected under A.R.S. §§ 36-140, 36-602, 36-603, 36-605, or by any other lawful means.

Historical Note

Adopted effective April 10, 1997 (Supp. 97-2).

ARTICLE 4. RENUMBERED

See Title 18, Chapter 8, Article 5.

ARTICLE 5. TRAILER COACH PARKS

R9-8-501. Reserved

R9-8-502. Reserved

R9-8-503. Reserved

R9-8-504. Reserved

R9-8-505. Reserved

R9-8-506. Reserved

R9-8-507. Reserved

R9-8-508. Reserved

R9-8-509. Reserved

R9-8-510. Reserved

R9-8-511. Legal authority

The regulations in this Article are adopted pursuant to the authority granted by A.R.S. § 36-136(G)(11).

R9-8-512. Definitions

A. "Department" means the Arizona Department of Health Services.

B. "Dependent trailer coach" means a trailer coach which does not have a flush toilet, bathtub, or shower.

C. "Independent trailer coach" means a trailer which has a flush toilet, bathtub or shower, and lavatory.

D. "Park" means a trailer coach park.

E. "Person" means any individual, firm, trust, partnership, company, society, association, corporation, or political subdivision.

F. "Trailer coach" means any vehicle including mobile homes having no foundation other than wheels, jacks, or skirtings, and so designed or constructed as to permit occupancy for dwelling or sleeping purposes. Removal of the wheels shall not change the meaning of the term.

G. "Trailer coach park" means any plot of ground upon which two or more trailer coaches, occupied for dwelling or sleeping purposes, are located regardless of whether or not a charge is made for such accommodation. This does not apply where all trailers are occupied by the owner of the plot and his immediate family, nor does it include areas provided for recreational purposes or overnight parking by agencies of the local, state

and federal governments, where posted restrictions for use of such areas are provided.

H. "Trailer coach space" means a plot of ground within a trailer coach park designed for the accommodation of one trailer coach.

R9-8-513. Reserved

R9-8-514. Reserved

R9-8-515. Reserved

R9-8-516. Reserved

R9-8-517. Reserved

R9-8-518. Reserved

R9-8-519. Reserved

R9-8-520. Reserved

R9-8-521. Plans and specifications

A. No construction on or at a trailer coach park shall commence until the Department has approved the plans and specifications for the public water supply and sewage disposal system.

B. No person shall maintain or operate a trailer coach park without the written approval of the local health department.

C. A park plan showing all building locations and trailer coach spaces shall be provided as part of the plans and specifications.

D. No change or modification of water supply or sewage disposal in any existing trailer coach park shall be made until plans and specifications have been submitted to and approved by the Department.

E. All plans and specifications shall be submitted to the Department in quadruplicate.

R9-8-522. Application

A. An application for approval by the Department, prepared in duplicate on forms furnished by the Department, shall be filed at the time the plans are submitted for approval. The form shall be completely filled out unless otherwise indicated.

B. The distance to the nearest public water supply main and to a sewer main of a municipal or community system shall be given.

R9-8-523. Park plan

A. The minimum size of trailer coach spaces shall be in compliance with regulations of local planning boards and other official agencies.

B. The park shall be located on a site which is properly graded to insure rapid drainage and the elimination of standing pools of water.

R9-8-524. Reserved

R9-8-525. Reserved

R9-8-526. Reserved

R9-8-527. Reserved

R9-8-528. Reserved

R9-8-529. Reserved

R9-8-530. Reserved

R9-8-531. Water supply

A. The public water supply and distribution systems to the trailer spaces and service building shall comply with all provisions of Article 2 of this Chapter.

B. The water supply system shall be so designed, constructed and maintained to provide a minimum supply demand of six fixture units at a residual pressure of not less than twenty pounds per square inch at each trailer site requiring water in addition to the water requirements of the service building.

C. Each independent trailer coach space shall be provided with a cold water tap at least four inches above the ground.

D. Hot water, a minimum of 120°F., shall be provided at all times in the service building for all bathing, washing, cleaning and laundry facilities.

R9-8-532. Reserved

R9-8-533. Sewage disposal system

A. The sewage disposal system shall comply with all provisions of Article 3 of this Chapter.

B. Where a public sewerage system is to be used and is already in existence, or if sewers are proposed and have been approved by the Department, it will only be necessary to show the location and size of the sewer lines within the park. Approval to construct the sewers serving the trailer park will not be given unless the capacity of the receiving sewers and the treatment facility which will receive the wastes is determined to have adequate capacity for the increased load resulting from the installation of the trailer park.

R9-8-534. Reserved

R9-8-535. Reserved

R9-8-536. Reserved

R9-8-537. Reserved

R9-8-538. Reserved

R9-8-539. Reserved

R9-8-540. Reserved

R9-8-541. Sanitation facilities

Toilets, bathing, laundry and other sanitation facilities shall be housed in a service building which shall present easy access from all trailer coach spaces by means of walkways or roadways.

R9-8-542. Service buildings

A. Service buildings shall be permanent structures, complying with all applicable ordinances and statutes regulating building construction.

B. Service buildings shall meet the following requirements:

1. All facilities shall be well lighted.
2. They shall be ventilated with screened openings.
3. They shall be constructed of such moisture-proof material, including painted woodwork, as shall permit repeated cleaning and washing.
4. Properly vented heating facilities shall be provided.
5. The floors of the service buildings shall be of water-impervious material and sloped to properly located floor drains.

C. Service buildings containing toilet and bathing facilities shall not be located farther than 200 feet from any dependent trailer coach space.

D. Existing parks serving dependent trailer coaches shall meet the requirements of this Section within six months from the effective date.

R9-8-543. Toilet facilities

A. All parks accommodating dependent trailer coaches shall be provided with the following number of toilets, showers and other sanitation facilities:

NUMBER OF FACILITIES REQUIRED IN SERVICE BUILDINGS

*Number of Trailer Parking Spaces	TOILETS		URINALS	LAVATORIES		SHOWERS		**Other
	Men	Women	Men	Men	Women	Men	Women	
1-15	1	1	1	1	1	1	1	1 service sink
16-30	1	2	1	2	2	1	1	with a flush-
31-45	2	2	1	3	3	1	1	ing rim
46-60	2	3	2	3	3	2	2	
61-80	3	4	2	4	4	2	2	1 utility sink
81-100	3	4	2	4	4	3	3	

For parking areas having more than 100 trailer spaces there shall be provided: 1 additional toilet and lavatory for each sex per each additional 30 trailer spaces; 1 additional shower for each sex per each additional 40 trailer spaces; and 1 additional men's urinal per each additional 100 trailer spaces.

*Parking spaces for dependent trailers, i.e., number of facilities required per number of dependent parking trailer spaces.

**Additional fixtures including laundry trays, clothes washing machines (one for every 30 sites) and an ice making machine may be provided.

B. Where a trailer coach park is designed for and exclusively limited to use by independent trailers, emergency sanitary facilities are not required.

C. When a park requiring a service building is operated in connection with a resort or other business establishment, the number of sanitary facilities for such business establishment shall be in excess of those required by the schedule for trailer spaces and shall be based on the total number of persons using such facilities.

R9-8-544. Community kitchens; recreational facilities
Trailer coach parks which provide a community kitchen or other recreational facilities shall comply with these rules and regulations relating to campgrounds and Article 2 of this Chapter relating to eating and drinking establishments.

R9-8-545. Reserved

R9-8-546. Reserved

R9-8-547. Reserved

R9-8-548. Reserved

R9-8-549. Reserved

R9-8-550. Reserved

R9-8-551. Waste disposal

A. The storage, collection, transportation and disposal of garbage, trash, rubbish, manure and other objectionable wastes shall be in accordance with the provisions of Article 4 of this Chapter.

B. Each trailer coach space shall be provided with a trapped sewer, at least three inches in diameter, which shall be connected to receive all liquid waste from the trailer coach located in such space. Except that a trapped sewer is not required in parks restricted to trailer coaches in which all fixtures discharge through a trap located in the trailer plumbing system.

R9-8-552. Reserved

R9-8-553. Reserved

R9-8-554. Reserved

R9-8-555. Reserved

R9-8-556. Reserved

R9-8-557. Reserved

R9-8-558. Reserved

R9-8-559. Reserved

R9-8-560. Reserved

R9-8-561. Enforcement
Any person who constructs, operates or maintains a trailer coach park contrary to the provisions of this Article is subject to the penalties provided by law.

ARTICLE 6. CAMP GROUNDS

R9-8-601. Reserved

R9-8-602. Reserved

R9-8-602. Reserved

R9-8-602. Reserved

R9-8-602. Reserved

R9-8-602. Reserved

R9-8-602. Reserved

R9-8-602. Reserved

R9-8-602. Reserved

R9-8-610. Reserved

R9-8-611. Scope
The regulations in this Article shall apply to any city, county, city and county, village, community, institution, person, firm or corporation operating, maintaining or offering for public use within the state of Arizona any tract of land on which persons may camp or picnic either free of charge or by payment of a fee. Each and every owner and lessee of any public camp or picnic ground shall be held responsible for full compliance with these regulations.

R9-8-612. Supervision

A. The management of every public camp or picnic ground shall assume responsibility for maintaining in good repair all sanitary appliances on said ground and shall promptly bring such action as may be necessary to prosecute or eject from such ground any person who willfully or maliciously damages such appliances or any person who in any way fails to comply with these regulations.

B. At least one caretaker shall be employed by the management to visit said camp or picnic ground every day that campers or picnickers occupy said ground. Such caretaker shall do whatever may be necessary to keep said ground and its equipment in a clean and sanitary condition.

C. Each camping party shall be allotted usable space of not less than 350 square feet.

R9-8-613. Water supply

A. The water supply system shall be in accordance with Article 2 of this Chapter and shall be provided in ample quantity to meet all requirements of the maximum number of persons using such ground at any time. Said water supply shall be easily obtained from its source or on a pipe distribution system from faucets which shall be located not more than 300 feet from a camp or picnic spot within such ground. If water supply is obtained direct from above-ground source, said source must be covered properly and water withdrawn by means of open pipe or faucet as approved by the Department. In no case can dipping from open springs, seeps or wells be permitted.

B. Any water considered unsafe for human consumption in the vicinity of such ground, to which campers or picnickers may have access, shall be either eliminated or purified or shall be kept posted with placards definitely warning persons against its use.

R9-8-614. Protection against fires

No fires shall at any time be so located as to endanger automobiles or other property in the camp ground. No fires shall be left unattended at any time, and all fires shall be completely extinguished before leaving.

R9-8-615. Sewage and refuse disposal

A. Supervision and equipment: Supervision and equipment sufficient to prevent littering of the ground with rubbish, garbage or other refuse shall be provided and maintained. Fly-tight depositories for such materials shall be provided and conspicuously located. Each and every camp or picnic spot on said ground shall be within a distance of not over 200 feet from such a depository. These depositories shall not be permitted to become foul smelling or unsightly or breeding places for flies.

B. The method of final sewage or refuse disposal utilized in connection with the operation of any camp or picnic ground shall be such as to create no nuisance.

C. Basins: A sufficient number of basins, iron hoppers or sinks shall be provided and each shall be connected with a sewerage system; these are to be used for the disposal of domestic waste waters.

R9-8-616. Toilets

Fly-tight privies or water-flushed toilets shall be provided and shall be maintained in a clean and sanitary condition. Separate toilets for men and women shall be provided, one for each 25 men and one for each 25 women or fraction thereof of the maximum number of persons occupying such ground at any time. No camp or picnic spot within such ground shall be at a greater distance than 400 feet from both a women's and men's toilet. The location of all toilets shall be plainly indicated by signs.

R9-8-617. Construction and maintenance of buildings

If cottages, cabins, tent houses, dwelling houses or other structures to be used for human habitation are erected in any public camping ground, the following requirements in their construction shall be observed: (Note: All local building ordinances must be complied with in addition to observing the following requirements.)

1. All wood floors shall be raised at least 18 inches above the ground and space underneath such floors shall be left open and free from obstruction on at least two opposite sides. All floors shall be constructed of tongue and groove material.
2. Interior walls shall be of surfaced lumber or other material that may easily be kept clean and shall be constructed so that they may always be kept in a thoroughly clean condition.
3. No room for sleeping purposes shall have less than 500 cubic feet of air space for each occupant.
4. The area of window space in each sleeping room shall be equal to at least one-eighth of the floor area of the room.
5. Windows of sleeping rooms shall be so constructed that at least half of each window can be opened.
6. Cooking, including the preparation and storing of food must not be allowed in any room used for sleeping. Partitions and doors between cooking and sleeping rooms must be tight.
7. If kitchen is provided, it must be equipped with running water and a sink connected with a sewerage system or septic tank. Kitchen must be screened against flies and mosquitoes.
8. If inside toilet is provided it must be water flushed and connected with a sewerage system or septic tank. Room containing such toilets must have window opening to the outside air. Bath and lavatory must be connected with sewerage system or septic tank.
10. Covered metal garbage containers must be provided, at least one for every two buildings.
11. Buildings shall be cleaned daily and after each occupancy shall be thoroughly cleaned. If bedding is provided it must be kept in a clean condition.

ARTICLE 7. SCHOOLS

R9-8-701. Reserved

R9-8-702. Reserved

R9-8-703. Reserved

R9-8-704. Reserved

R9-8-705. Reserved

R9-8-706. Reserved

R9-8-707. Reserved

R9-8-708. Reserved

R9-8-709. Reserved

R9-8-710. Reserved

R9-8-711. Sanitation; general

A. Regulations in this Article shall apply to any public, private or parochial school.

B. The yards shall be free of puddles and clean.

C. The school building structurally shall have a watertight roof and interior walls of even cleanable surfaces.

D. Ventilation, whether natural or artificial shall be non-noxious and controlled to prevent objectionable air currents on students.

E. Cafeterias or lunchrooms shall have a minimum window area equal to 12 1/2% of the floor area.

R9-8-712. Water supply

A. Each school building shall be provided with an ample supply of water, preferably from an approved municipal or public water supply system. If such a system is not available, water from an underground source approved by the Department may be obtained. Such separate supplies must meet the requirements of Article 2 of this Chapter and school authorities shall be responsible for the submission of samples for bacteriologi-

cal analysis to the Arizona Department of Health Services Laboratory. All pumps shall be maintained in good working order and an adequate supply of water shall be maintained. There shall be adequate pressure and quantity to operate all water supply fixtures efficiently at all times.

B. Drinking water shall be dispensed by means of:
1. An angle jet sanitary fountain with nozzle opening above overflow rim, and producing a water stream free of contact with fixtures; or
2. A sanitary cooler, of a type approved by the Department, and single-service paper cups retained in a sanitary container.

C. The use of the common drinking cup and the vertical jet bubbler type fountain is prohibited.

D. The minimum number of drinking fountains shall be provided on the following basis:
1. Elementary grades -- one for each 50 students.
2. Junior and Senior high schools and colleges -- one for each 100 students.
3. A minimum of one fountain on each classroom floor.

R9-8-713. Sanitary facilities

A. The minimum number of sanitary facilities shall be provided on the following basis:

Slop sink - One each story
(inc. basement)

B. Paper towels and soap shall be furnished in all lavatories. Common towels are prohibited. General toilet rooms should be ventilated by means of a forced air exhaust system.

C. Toilet paper shall be available at all times.

D. Lavatories with hot and cold or tempered running water are required and shall be located in toilet rooms or immediately adjacent thereto. On new construction or replacement, sanitary toilet seats of the split or U-shaped type made of non-absorbent material shall be installed.

E. In rural schools, where handwashing facilities are not located in the toilet rooms, one lavatory shall be provided for each school room.

F. Toilet room floors shall be constructed of concrete or other water-impervious material pitched to a suitably located trapped floor drain. In new construction the floor drains shall be connected by means of a separate line to the building sewer. If partitions are provided between flush bowls, they shall be raised at least 12" from the floor.

R9-8-714. Showers

A. When athletic or gymnastic activities are conducted in a school, showers shall be provided. There shall be one showerhead for each 6 users, based upon the maximum demand at any one period.

B. Shower and locker rooms, when provided, shall be constructed with concrete or other impervious floors pitched to a suitable trapped drain and the walls and ceilings shall be of smooth, easily-washable material. These rooms shall be sufficiently well ventilated to prevent the accumulation of disagreeable odors and condensation upon interior surfaces. If lockers are provided, they shall be set on a solid base or raised 6" above the floor if open underneath. In all new construction lockers shall be set on a solid base.

C. If the bath towels are supplied by the school, they shall be for individual use only and shall be laundered before reissue.

R9-8-715. Sewage disposal

A. All liquid wastes from a school building shall be discharged into a public sewerage system when possible. When a public sewerage system is not available, liquid wastes shall be disposed of into a septic tank system approved by the Department as provided in Article 3 of this Chapter.

B. Privies shall not be approved except in extreme cases. Where used, they shall be of a standard type approved by the Department.

C. All plumbing shall comply with local regulation and the standards adopted by reference in R9-1-412(D).

R9-8-716. Garbage and refuse

A. Fly-proof and water-tight metal containers shall be provided for garbage. Garbage cans shall be emptied at least three times weekly, thoroughly washed, and never allowed to become foul smelling or a breeding place for flies.

B. Combustible rubbish shall be collected in metal-covered containers and disposed of in a safe and sanitary manner.

C. Garbage and refuse shall be disposed of in a manner which creates neither a nuisance nor a menace to health and in conformance with the requirements of Article 4 of this Chapter.

R9-8-717. Food handling

Article 1 of this Chapter is applicable to all schools where food is handled, stored or sold.

ARTICLE 8. PUBLIC AND SEMIPUBLIC BATHING PLACES

R9-8-801. Reserved

R9-8-802. Reserved

R9-8-803. Reserved

R9-8-804. Reserved

R9-8-805. Reserved

R9-8-806. Reserved

R9-8-807. Reserved

R9-8-808. Reserved

R9-8-809. Reserved

R9-8-810. Reserved

R9-8-811. Definitions

A. "Approved" means acceptable to the Department.

B. The term "bathing place" as used in these regulations includes all bodies of water used collectively by a number of persons for swimming, wading or recreation bathing purposes, together with the shores, bathhouse, sanitary facilities, bathing suits, equipment and appurtenances pertaining to such bathing places; except that these regulations do not apply to private swimming pools as herein defined, nor do they include baths used for cleansing purposes, hydrotherapy or for the healing arts, unless such baths consist of a pool or pools used collectively by a number of individuals.

C. "Construct" means, and includes, building or installing a new bathing place or enlarging or altering existing facilities.

D. "Cross connection" is any physical connection or arrangement between two otherwise separate piping systems, one of which contains potable water and the other sewage or water of unknown or questionable safety, through which water may flow from one system to the other, the direction of flow depending on the pressure differential between the two systems.

E. "Department" means the Arizona Department of Health Services or its designated representative.

F. "Fill and draw pool" means a swimming pool where the principal means of cleaning is the complete removal of the used water and the replacement thereof with clean water.

G. "Flow through pool" means a swimming pool where clean water constantly enters the pool and an equal quantity of used water constantly flows out of the pool.

H. "Natural bathing place" includes natural outdoor lakes, ponds, rivers, etc.

I. "Operate" means to conduct, maintain or otherwise provide facilities and appurtenances at bathing places.

J. "Private pool" means a pool established or maintained on any premise by an individual for his own or his family's use or for guests of his household.

K. "Public pool" means a swimming pool such as municipal, community, commercial, or cooperative, admission to which may be gained by the general public with or without payment of a fee.

L. "Recirculating pool" means a swimming pool where a portion of the pool water is constantly being removed, treated, filtered and disinfected and then returned to the pool.

M. "Semi-artificial bathing place" means outdoor bathing places which are partly artificial and partly natural in character.

N. "Semipublic pool" means a swimming pool on the premises of, or part of, a hotel, motel, trailer court, apartment house, country club, camp or similar establishment where the primary business of the establishment is not the operation of swimming facilities and where admission to the use of the pool is included in the fee, or consideration paid or given for the primary use of the premises.

O. "Spray pond" means an artificially constructed basin into which water is sprayed but not allowed to accumulate.

P. "Swimming pool" means, and includes, all entirely artificially constructed fill and draw, flow through or recirculating pools, either indoors or outdoors.

Q. "Wading pool" means a shallow pool intended chiefly for use by children, having a separate basin to contain the water and a maximum water depth of 20 inches.

R9-8-812. Water quality standards

A. Quality of water -- Swimming pool water shall be so treated and maintained, whenever the swimming pool is open for use, that the bacterial, chemical and physical quality of the water meets the standards set forth in this Article.

B. Only water from approved sources shall be used in swimming pools and other bathing places.

C. Bacterial standards -- Of any 3 consecutive dechlorinated samples of the pool water collected when the pool is open for use:

1. None shall contain more than 200 bacteria per milliliter nor shall the average bacteria count of the 3 samples exceed 100 per milliliter.
2. At least 60% of the 10 milliliter portion shall give a negative test for bacteria of the coliform group and no sample shall show positive for the coliform group in 3 out of 5 ten-milliliter portions.

D. Chemical standards -- Whenever chlorine, or a chlorine compound, is employed for swimming pool disinfection, the amount of free chlorine in the water as shown by the orthotolidine "flash" test shall not be less than 0.4 ppm nor more than 1.0 ppm; nor shall the pH of the water be less than 7.0 nor more than 8.0, except that higher residuals will be allowed with corresponding increase in pH. During periods of heavy bathing loads, disinfection residuals shall be maintained near the upper limits of the permissible range.

E. Physical standards -- The surface of the pool water shall be kept free of scum and foreign floating matter. The bottom and sides of the pool shall be maintained free of sediment, dirt, slime and algae. Water in the pool shall be maintained free of turbidity and shall be sufficiently clear so that the main drain grille is clearly visible from the side of the pool.

F. Tests -- Tests of the residual disinfectant, pH, temperature and cleanliness of the pool water shall be made by the operator as frequently as necessary to maintain the standards required by this regulation. The pool operator shall use approved equipment suitable for the performance of these tests and shall maintain daily operating records. Such records shall be made available to state and county health department officials upon request.

R9-8-813. Life guards; safety equipment

A. In all public pools one life guard, expert in rescue and resuscitation, shall be provided for each 2,000 square feet of pool surface area or fraction thereof.

B. Life guards shall be in constant attendance during bathing hours and no bather shall be permitted in a pool area unless such life guards are present.

C. Each public swimming pool shall have at least one elevated life guard chair for each 2,000 square feet of pool surface or fraction thereof.

D. Safety equipment consisting of at least 2 ring buoys, each with 50 feet of 1/2 inch rope attached, and one shepherd's crook shall be provided at each public pool. One ring buoy, with lifeline attached, and one shepherd's crook shall be provided at each semipublic pool. Safety equipment shall be located and maintained ready for immediate use at all times.

E. A lifeline shall be installed in all public swimming pools at the change in floor slope between the shallow and deep portions of the pool. The lifeline shall be 3/4 inch minimum diameter.

R9-8-814. Excluded persons

Persons with sore or inflamed eyes, colds, nasal or ear discharges, boils or other acute or obvious skin or body infections, or cuts shall be excluded from the pool. No person in or at a swimming pool shall commit, or be permitted to commit, any act prejudicial to the life or health of any other person using the pool.

R9-8-815. Instructions

All persons shall be instructed before entering the pool, by means of suitable, clearly lettered signs properly located, to use the toilet, take a cleansing shower and observe all safety regulations.

R9-8-816. Suits and towels

Bathing suits, towels, linens or similar articles provided to patrons shall be properly washed with soap and boiling water and thoroughly dried after each individual use and before another use.

R9-8-817. First-aid kit

There shall be provided for emergency use a standard first-aid kit. In addition, at public pools, a standard stretcher and two blankets shall be provided.

R9-8-818. Reserved

R9-8-819. Reserved

R9-8-820. Reserved

R9-8-821. Repealed

Historical note

R9-8-821 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-822. Repealed

Historical note

R9-8-822 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-823. Concessions
Drinks, candy, tobacco, popcorn, gum, or food of any kind shall not be permitted within the pool enclosure.

R9-8-824. Operation
All bathing place facilities shall be operated and maintained in a clean and sanitary condition at all times.

R9-8-825. Reserved

R9-8-826. Reserved

R9-8-827. Reserved

R9-8-828. Reserved

R9-8-829. Reserved

R9-8-830. Reserved

R9-8-831. Repealed

Historical Note
R9-8-831 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-832. Repealed

Historical Note
R9-8-832 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-833. Repealed

Historical Note
R9-8-833 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-834. Repealed

Historical Note
R9-8-834 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-835. Repealed

Historical Note
R9-8-835 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-836. Repealed

Historical Note
R9-8-836 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-837. Repealed

Historical Note
R9-8-837 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-838. Approval to operate
Operation of newly constructed public or semipublic bathing places shall not commence before a final inspection has been made and approval to operate has been given by the local health department. Where a local health department does not exist the final inspection shall be made by the Department.

R9-8-839. Repealed

Historical Note
R9-8-839 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-840. Reserved

R9-8-841. Repealed

Historical Note
R9-8-841 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

Exhibit A. Repealed

Historical Note
Exhibit A repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-842. Repealed

Historical Note
R9-8-842 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-843. Repealed

Historical Note
R9-8-843 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-844. Repealed

Historical Note

R9-8-844 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-845. Repealed

Historical Note

R9-8-845 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-846. Repealed

Historical Note

R9-8-846 repealed by summary action with an interim effective date of July 6, 1998; filed in the Office of the Secretary of State June 8, 1998 (Supp. 98-2). Adopted summary rules filed October 9, 1998; interim effective date of July 6, 1998, now the permanent effective date (Supp. 98-4).

R9-8-847. Design standards and specifications; natural and semi-artificial bathing places

A. Approval of natural and semi-artificial bathing places will be based upon the results of a sanitary survey of the drainage area and the results of bacteriological, chemical and physical quality of the water in the proposed bathing area.

B. The water shall be considered acceptable for bathing purposes, from a bacterial standpoint, when the average MPN of coliform organisms of a representative number of samples is not greater than 1000 per 100 ml.

C. A bathing place shall be located so that it will not be adversely affected by the discharge of sewage or objectionable industrial wastes; nor shall it be so located that by its use it will affect the source of supply of a public water supply system.

D. The provisions of R9-8-846 shall apply to all natural and semi-artificial bathing places, except that hot water for showers and lavatories may not be required.

R9-8-848. Reserved

R9-8-849. Reserved

R9-8-850. Reserved

R9-8-851. Violations

Any person, firm, company, corporation or political subdivision constructing, operating or maintaining a public or semipublic bathing place contrary to the provisions of these rules shall be prosecuted in accordance with A.R.S. § 36-140.

Historical Note

Editorial correction, spelling of "political" (Supp. 89-2).

R9-8-852. Inspections

Inspections of public and semipublic bathing places shall be made by representatives of the state or county health departments to determine that installed facilities and operational procedures comply with these rules. Should the Department, after inspection of a bathing place, find that an extreme safety or health hazard exists, they may order the immediate suspension of the operation of the establishment. Such suspension of operation shall continue until, in the opinion of the Department, the hazard has ceased to exist. The Department may suspend operation for repeated or continued violation of any of the Department's rules.

ARTICLE 9. BEDDING

R9-8-901. Definitions

In addition to the definitions contained in A.R.S. § 36-796, in this Article, unless otherwise specified:

1. "Applicant" means the following persons requesting a license:
   a. If an individual, the individual owning the bedding establishment;
   b. If a corporation, any 2 officers of the corporation;
   c. If a limited liability company, the designated manager or, if no manager is designated, any 2 members of the limited liability company;
   d. If a partnership, any 2 of the partners; or
   e. If a joint venture, any 2 individuals signing the joint venture agreement.
2. "Bedding establishment" means a store or factory where a bedding is manufactured, renovated, or treated.
3. "Disinfect" means to kill bacteria, fungi, and parasites of human significance on the surface of a secondhand bedding by applying a liquid spray containing microbicide, fungicide, and insecticide over the surface of the secondhand bedding.
4. "Labeling" means the handwritten, printed, and graphic information displayed on a bedding tag under A.R.S. § 36-796.02 and the rules contained in this Article.
5. "License" means authorization by the Department to manufacture, renovate, or treat a bedding.
6. "Manufacture" means to make a bedding using new or secondhand material or a mixture of both new and secondhand material.
7. "Petition" means a request for approval of an alternate treatment method.
8. "Sterilize" means to kill all microorganisms and parasites in or on a bedding by either a penetrating chemical or cumulative heat.
9. "Tag" means a card, flap, or strip attached to a bedding.
10. "Treat" means to clean and disinfect or sterilize a bedding or filling material.

Historical Note

Adopted effective October 9, 1998 (Supp. 98-4).

R9-8-902. Bedding License Application

A. An applicant shall complete and submit to the Department a bedding license application form supplied by the Department that contains all of the following:
1. The full name and mailing address of the applicant,
2. The name of the bedding establishment,
3. The street address for the bedding establishment,
4. The telephone number for the bedding establishment,
5. The classification of bedding license requested,
6. The license number of each bedding license held in Arizona or any other state by the applicant,
7. A description of any treatment method the applicant plans to use, and
8. The signature of the applicant and the signature date.

B. An applicant intending to operate bedding establishments at multiple locations shall submit a completed license application for each location.

C. An applicant may request the same license number issued to the applicant by a different state. The Department may issue a license with the requested license number, provided the number is not already in use in Arizona.

Historical Note

Adopted effective October 9, 1998 (Supp. 98-4).

R9-8-903. Time-frames

A. This Section applies to a bedding license under R9-8-902 or a petition under R9-8-917.
B. The overall time-frame described in A.R.S. § 41-1072(2) is 60 days for a bedding license and 30 days for a petition.
C. The administrative completeness review time-frame described in A.R.S. § 41-1072(1) is 30 days for a bedding license and 15 days for a petition and begins on the date the Department receives an application.
1. If any of the application documents is missing or if information on the submitted documents is deficient, the Department shall send to the applicant, by certified mail with return receipt, a written notice that states each deficiency and information and document needed to complete the application. The 30-day time-frame for a bedding license and the 15-day time-frame for a petition for the Department to finish the administrative completeness review are suspended from the postmark date of the deficiency notice to the applicant until the date the Department receives the deficient information or missing document.
2. If all of the documents are submitted and the information on the documents is complete, the Department shall send a written notice of administrative completeness to the applicant.
3. If the documents or information are not submitted within 180 days from the postmark date of notice of incompleteness for a bedding license and 90 days for a petition, the Department shall consider the application withdrawn.
4. If the Department grants a license or approves a petition during the time provided to assess administrative completeness, the Department shall not issue a separate written notice of administrative completeness.

D. The substantive review time-frame described in A.R.S. § 41-1072(3) is 30 days for a bedding license and 15 days for a petition, and begins on the postmark date of the notice of administrative completeness.
1. For a bedding license, as part of the substantive review, the Department may schedule an inspection that may require more than 1 visit to the establishment.
2. If an applicant or establishment does not meet the requirements of A.R.S. §§ 36-796 through 36-796.08 and this Article, the Department shall provide to the applicant a written notice of nonconformance that states each statute and rule upon which nonconformance is based.
   a. Within 120 days for a bedding license and 60 days for a petition from the date of receipt of a written notice of nonconformance, the applicant shall submit to the Department additional information under A.R.S. § 41-1075 that consists of written documentation of the corrections required in the notice of nonconformance. The time-frame for the Department to finish the substantive review is suspended from the date the Department provides the written notice of nonconformance to the applicant until the Department receives documentation of corrections.
   b. The Department shall issue a written notice of denial as prescribed in A.R.S. § 41-1076, if:
      i. The applicant does not submit documentation of corrections within the time-frame in subsection (C)(2)(a); or
      ii. Upon receipt of documentation of corrections from the applicant, the Department determines that the applicant or establishment does not meet the requirements of A.R.S. §§ 36-796 through 36-796.08 and this Article.
3. If the applicant or establishment meet the requirements of A.R.S. §§ 36-796 through 36-796.08 and this Article, the Department shall issue a license to or approve the petition of the applicant.

D. If a time-frame's last day falls on a Saturday, Sunday, or a legal holiday, the next business day will be considered the time-frame's last day.

Historical Note
Adopted effective October 9, 1998 (Supp. 98-4).

R9-8-904. Issuance of License
A. A bedding license issued by the Department shall bear the following information:
1. The name of the bedding establishment;
2. The street address of the bedding establishment;
3. The full name of the licensee;
4. The mailing address of the licensee;
5. The license classification; and
6. A unique identifying number, as determined by the Department.

B. A license issued by the Department is nontransferable.

Historical Note
Adopted effective October 9, 1998 (Supp. 98-4).

R9-8-905. License Classification
The Department shall issue the following types of bedding licenses:
1. Type "M" authorizing a person to manufacture a bedding from all new material, for either wholesale or retail sale; or
2. Type "R" authorizing a person to manufacture, renovate, or treat a bedding that contains, in whole or in part, secondhand material, for wholesale or retail sale.

Historical Note
Adopted effective October 9, 1998 (Supp. 98-4).

R9-8-906. License Suspension or Revocation
A. The Department may suspend or revoke a bedding license if the Department determines that the licensee has:
1. Violated the rules of this Article or the provisions of A.R.S. §§ 36-796 through 36-796.08, or
2. Provided false information on a license application.

B. The Department shall serve notice that complies with A.R.S. § 41-1092.04 of a pending suspension or revocation action to a licensee.
C. A license revocation or suspension hearing shall be conducted by the Office of Administrative Hearings under A.R.S. Title 41, Chapter 6, Article 10.

Historical Note
Adopted effective October 9, 1998 (Supp. 98-4).

R9-8-907. Off-sale Procedure
A. The Department shall issue an Off-sale order suspending the sale or potential sale of a bedding that violates the rules of this Article or the provisions of A.R.S. §§ 36-796 through 36-796.08.
B. An Off-sale order shall contain all of the following:
1. The date of issue;
2. The name of the bedding owner, if known;
3. The street address where the bedding is located;
4. The name of the licensee, if known;
5. The mailing address of the licensee, if known;
6. The license number of the licensee, if known;
7. The specific reason for the Off-sale order; and
8. The identifying number on the Off-sale tag attached to a bedding under subsection (C).

C. Under A.R.S. § 36-796.01(E), a Department representative shall use a rubber, plastic, or metal cord to attach an Off-sale tag to a bedding.

D. An Off-sale tag shall not be defaced, altered, or concealed from view.

E. An Off-sale tag shall be removed from a bedding only as provided in subsection (F).

F. A bedding ordered Off-sale shall not be sold or offered for sale until:
1. A Department representative issues a Release for Sale order and removes the Off-sale tag, or
2. The Department sends a Release for Sale order, by certified mail, instructing the licensee or bedding owner to remove the Off-sale tag.

Historical Note
Adopted effective October 9, 1998 (Supp. 98-4).

R9-8-908. Off-sale Tag Requirements

A. An Off-sale tag shall measure no less than 12 square inches in size.

B. The labeling on an Off-sale tag shall comply with the general requirements contained in R9-8-911(A) and bear all of the following:
1. A unique identifying number, as determined by the Department;
2. The statements:
   a. "THIS BEDDING SHALL NOT BE SOLD BECAUSE IT DOES NOT COMPLY WITH THE BEDDING ACT OF THE STATE OF ARIZONA"; and
   b. "THIS TAG SHALL BE REMOVED ONLY AS PROVIDED IN A.A.C. R9-8-907(F)";
3. The description of the bedding;
4. The signature of the Department representative; and
5. The date that the Off-sale tag is signed by the Department representative.

Historical Note
Adopted effective October 9, 1998 (Supp. 98-4).

R9-8-909. Uniform Classification and Description of Filling Materials

A manufacturer or renovator shall describe a filling material using only the terms, words, and phrases adopted by the Association of Bedding and Furniture Law Officials in the "1996 Tagging Law Manual" (1996 Edition), pages 17 through 27, published by the International Sleep Products Association, 333 Commerce Street, Alexandria, VA, 22314, incorporated by reference, and on file with the Department and the Office of the Secretary of State. This incorporation by reference includes no future editions or amendments.

Historical Note
Adopted effective October 9, 1998 (Supp. 98-4).

R9-8-910. Prohibited Filling Materials

In addition to the prohibited filling materials listed in A.R.S. § 36-796.03, a licensee shall not use a filling material containing any of the following:
1. Animal or insect excrement;
2. Animal skin;
3. Decayed animal or plant matter;
4. Dirt;
5. Insects;
6. Plant leaves;
7. Plant stems;
8. Trash; or
9. More than 5% by weight of oil, grease, fat, or a combination thereof.

Historical Note
Adopted effective October 9, 1998 (Supp. 98-4).

R9-8-911. General Requirements for a Bedding Tag

A. A white, red, green, or yellow bedding tag required under this Article shall comply with all of the following:
1. The labeling on the tag shall be:
   a. Imprinted on only 1 side of the tag,
   b. No less than 1/16 inch high,
   c. In English, and
   d. In permanent black ink that does not rub or flake off.
2. The tag shall:
   a. Be made of polyolefin, plastic, vinyl, teslin, vellum cloth, or equivalent material that does not lose its labeling information when folded;
   b. Contain the statement: "UNDER PENALTY OF LAW THIS TAG SHALL NOT BE REMOVED EXCEPT BY THE CONSUMER" at the top of the tag;
   c. Be securely fastened to a completed bedding at the place of treatment or manufacture; and
   d. Not be concealed or obstructed from view.

B. A tag may contain additional information, provided the additional information is not inconsistent or contrary to the requirements of A.R.S. §§ 36-796 through 36-796.08, or this Article.

Historical Note
Adopted effective October 9, 1998 (Supp. 98-4).

R9-8-912. Tag and Labeling Required on New Bedding

A. A type "M" licensee shall attach a white tag, no less than 6 square inches in size, to each bedding manufactured by the licensee.

B. A white tag shall bear all of the following specific labeling:
1. The statement: "ALL NEW MATERIAL CONSISTING OF:", and a description of the contents in print no less than 1/8 inch high;
2. A description of the filling materials in accordance with R9-8-909;
3. An Arizona license number;
4. The percentage, by weight, of the different filling materials present, listed by descending order of prevalence from the most to the least; and
5. The statement: "THE MANUFACTURER CERTIFIES THAT THE MATERIALS IN THIS BEDDING ARE DESCRIBED IN ACCORDANCE WITH LAW,".

Historical Note
Adopted effective October 9, 1998 (Supp. 98-4).

R9-8-913. Tag and Labeling Required on Renovated Bedding

A. A type "R" licensee shall attach a red tag, no less than 12 square inches in size, to each bedding manufactured by the licensee that contains any secondhand material. A red tag shall bear all of the following specific labeling:
1. The words: "SECONDHAND MATERIAL", in letters 1/4 inch high;
2. A description of the filling materials in accordance with R9-8-909;
3. An Arizona license number; and
4. The statement: "THE MANUFACTURER CERTIFIES THAT THE MATERIALS IN THIS BEDDING ARE DESCRIBED IN ACCORDANCE WITH LAW".

B. A type "R" licensee shall attach a green tag, no less than 6 square inches in size, to a bedding renovated for the personal use of the bedding's owner. A green tag shall bear all of the following specific labeling:

1. The statement: "NOT FOR SALE, OWNER'S OWN MATERIAL WHICH IS SECONDHAND MATERIAL", in letters no less than 1/4 inch high;
2. The statement: "THE RENOVATOR CERTIFIES THAT THIS BEDDING WAS RECEIVED FROM THE OWNER FOR RENOVATION AND CONTAINS ONLY MATERIAL PROVIDED BY THE OWNER, PART OR ALL OF WHICH IS SECONDHAND MATERIAL CONSISTING OF:";
3. A description of the filling materials in accordance with R9-8-909;
4. The name and address of the owner of the bedding;
5. An Arizona license number; and
6. The renovation completion date.

Historical Note
Adopted effective October 9, 1998 (Supp. 98-4).

R9-8-914. Tag and Labeling Required on Secondhand Bedding

A. In addition to a red or green tag required under R9-8-913, a type "R" licensee shall attach a yellow tag, no less than 12 square inches in size, to each secondhand bedding and each renovated bedding that is manufactured in whole or in part from secondhand material.

B. A yellow tag shall bear all of the following specific labeling:
1. The treatment method used,
2. The license number of the licensee,
3. The date treated, and
4. A unique identifying number supplied by the licensee.

C. In addition to the labeling requirements in subsection (B), a yellow tag attached to a disinfected secondhand bedding shall bear all of the following specific labeling:
1. The statement: "THE RENOVATOR CERTIFIES THAT THIS SECONDHAND BEDDING HAS BEEN DISINFECTED BY A METHOD APPROVED BY THE ARIZONA DEPARTMENT OF HEALTH SERVICES"; and
2. The words: "SECONDHAND", "BEDDING", and "DISINFECTED", in letters no less than 1/4 inch high.

D. In addition to the labeling requirements in subsection (B), a yellow tag attached to a sterilized secondhand bedding shall bear all of the following specific labeling:
1. The statement: "THE RENOVATOR CERTIFIES THAT THIS SECONDHAND BEDDING HAS BEEN STERILIZED BY A METHOD APPROVED BY THE ARIZONA DEPARTMENT OF HEALTH SERVICES"; and
2. The words: "SECONDHAND", "BEDDING", and "STERILIZED", in letters no less than 1/4 inch high.

Historical Note
Adopted effective October 9, 1998 (Supp. 98-4).

R9-8-915. Treatment of Secondhand Bedding

Except as provided in A.R.S. § 36-796.07, a person shall not sell or offer for sale a bedding containing any secondhand material unless it has been cleaned and disinfected or sterilized.

Historical Note
Adopted effective October 9, 1998 (Supp. 98-4).

R9-8-916. Treatment Record

A. A type "R" licensee shall maintain a treatment record for each bedding and filling material that the licensee treats.

See Title 18, Chapter 5, Article 4.

1. A bedding treatment record shall contain:
   a. The treatment date,
   b. A description of the bedding,
   c. The treatment method, and
   d. The unique number required on the yellow tag under R9-9-914(B)(4).
2. A filling material treatment record shall contain:
   a. The treatment date,
   b. The description of the filling material,
   c. The treatment method, and
   d. The full name and address of the person for whom the filling material was treated.

B. A type "R" licensee shall keep each treatment record for a period of 1 year from the date of treatment.

Historical Note
Adopted effective October 9, 1998 (Supp. 98-4).

R9-8-917. Recommended Treatment Methods

A. The following treatment methods are approved by the Department:
1. Sterilization by steam for 30 minutes at a pressure of 15 pounds per square inch and a temperature of 250° F, or for 20 minutes a pressure of 20 pounds per square inch and a temperature of 260° F. A charting device installed on the sterilization chamber shall measure and record the chamber pressure and temperature over time.
2. Sterilization by dry heat at a temperature of 230° F for 2 hours. A charting device installed on the sterilization chamber shall measure and record the temperature over time.
3. Sterilization by submersion in boiling water for 10 minutes.
4. Sterilization through a commercial dry cleaning process.
5. A secondhand bedding may be disinfected by the application of a spray disinfectant registered by the United States Environmental Protection Agency for use on a bedding. The product shall be applied according to the manufacturer's instructions.

B. A licensee may submit a petition to the Department requesting the approval of an alternate treatment method.
1. The petition shall contain:
   a. The full name, address, and telephone number of person submitting the petition;
   b. A detailed description of the proposed alternate treatment method;
   c. A written justification for the use of an alternate treatment method; and
   d. Any data, including laboratory test data, which demonstrates the effectiveness of the proposed alternate treatment method.
2. The Department shall approve the alternative treatment method if it determines that the proposed method complies with the requirements of A.R.S. §§ 36-796 through 36-796.08 and this Article.

Historical Note
Adopted effective October 9, 1998 (Supp. 98-4).

ARTICLE 10. RENUMBERED

ARTICLE 11. REPEALED

Article 11, consisting of Sections R9-8-1111, repealed effective April 10, 1997 (Supp. 97-2).

R9-8-1111. Repealed

Historical Note

Repealed effective April 10, 1997 (Supp. 97-2).

See Title 18, Chapter 8, Article 6.

ARTICLE 13. HOTELS, MOTELS, AND TOURIST COURTS

R9-8-1301. Reserved

R9-8-1302. Reserved

R9-8-1303. Reserved

R9-8-1304. Reserved

R9-8-1305. Reserved

R9-8-1306. Reserved

R9-8-1307. Reserved

R9-8-1308. Reserved

R9-8-1309. Reserved

R9-8-1310. Reserved

R9-8-1311. Legal authority

The regulations in this Article are adopted pursuant to the authority granted by A.R.S. § 36-136(G)(11).

R9-8-1312. Definitions

A. "Approved" means acceptable to the Department.

B. "Department" means the Arizona Department of Health Services or a local health department designated by the Arizona Department of Health Services.

C. "Dwelling unit" means any suite, room, cottage, bedroom, or other unit established or maintained by a transient dwelling establishment for temporary occupancy.

D. "Person" means the state, a municipality, district, or other political subdivision, a cooperative, institution, corporation, company, firm, partnership, or individual.

E. "Plumbing or plumbing system" means and includes the water supply distributing pipes; the fixtures and fixture traps; the soil, waste, and vent pipes; and the building drains with their devices, appurtenances and connections either within or adjacent to the transient dwelling establishment.

F. "Transient" means any member of the public who occupies a dwelling unit on a temporary basis in a transient dwelling establishment as defined above.

G. "Transient dwelling establishment" means and includes any place where sleeping accommodations are available to transients or tourists on a temporary basis such as a hotel, motel, motor hotel, tourist court, tourist camp, rooming house, boarding house, inn, and similar facilities by whatever name called, consisting of two or more dwelling units; provided, however, that the term shall not be construed to include apartments, clubs, boarding houses, rooming houses, and similar facilities where occupancy of all dwelling units is on a permanent or semi-permanent basis.

R9-8-1313. Permits

A. No person shall operate a transient dwelling establishment without first obtaining a permit from the local health department having jurisdiction. The owner, lessee, or operator of each transient dwelling establishment in operation upon the effective date of these regulations shall within ninety days thereafter obtain a permit, and the transient dwelling establishment shall comply in all respects with the requirements of these regulations; provided that the local health department upon proof of necessity made by the person concerned may, at its discretion, extend the time for compliance with any particular Section or Sections thereof.

B. An application for a permit to operate a transient dwelling establishment shall be made in duplicate by the owner, lessee, or operator to the local health department on forms furnished by the Department. Such forms shall be complete in all details and, in the case of new transient dwelling establishments, or additions and alterations to existing transient dwelling establishments, shall include plans and specifications of the proposed sanitary facilities and any other information as may be required by the local health department. Such permit will not be issued until the proposed or existing transient dwelling establishment complies with the provisions of these regulations.

C. The permit shall be posted in a conspicuous place designated by the local health department.

D. A permit may be revoked, denied or suspended by the local health department for failure or violation of any of the terms of these regulations or at any time when, in the opinion of the local health department having jurisdiction, the transient dwelling establishment has or may become a menace to public health.

E. Permits shall be valid for the calendar year for which they are issued, or as otherwise specified by the local health department, and shall be renewed in accordance with the requirements of the local health department. Permits are not transferable, either from person to person or from one location to another location.

R9-8-1314. Inspection

Representatives of the local health department shall make such inspections of any transient dwelling establishment as are necessary to assure compliance with these regulations, but not less than once each year. A copy of the report of the inspection shall be furnished the owner, lessee, or operator of the transient dwelling establishment indicating the degree of compliance or non-compliance with the provisions of these regulations. Failure to correct any discrepancies noticed within the time limit specified shall be cause for denial, revocation, or suspension of the permit to operate.

R9-8-1315. Notification of disease

A. The owner or operator of a transient dwelling establishment shall report to the local health department the name of any guest or employee suspected or known to have a contagious disease in accordance with A.R.S. Title 36, Chapter 6, Article 2.

B. Every dwelling unit, after being occupied by a person known or suspected of having a contagious disease, shall be rendered noncontagious by disinfection, fumigation, or by other treatment methods as specified by the local health department before further occupancy.

R9-8-1316. Reserved

R9-8-1317. Reserved

R9-8-1318. Reserved

R9-8-1319. Reserved

R9-8-1320. Reserved

R9-8-1321. Dwelling units

A. Dwelling units shall be of sufficient size to afford ample circulation of air and freedom of movement, but not less than 100 square feet of floor area shall be provided for each unit, exclusive of bathrooms, closets, kitchens, and similar ancillary facilities.

ARTICLE 12. RENUMBERED

B. Floors of all rooms shall be of such construction as to be easily cleaned and shall be kept clean and in good repair.
C. The walls and ceilings of all rooms shall be of a finish that will permit easy cleaning and shall be kept clean and in good repair.
D. Where windows are relied on to provide light and ventilation, the area of the windows for each dwelling unit shall be equal to at least 20% of the floor area.
E. Not less than 25% of the window area furnished shall be capable of being opened unless other satisfactory means of ventilation is provided. Windows capable of being opened shall be effectively screened.
F. Furniture, drapes, carpets, and other accessories shall be kept clean and in good repair.
G. Dwelling units shall be maintained free of insects, rodents, and other vermin.
H. The provisions of A.R.S. Title 36, Chapter 13, Article 2 relating to gas appliances shall be met.

R9-8-1322. Grounds
A. Grounds of a transient dwelling establishment shall be properly graded and drained.
B. Grounds shall be kept clean and free of accumulations of refuse and other debris. There shall be no evidence of fly, mosquito, or rodent breeding or infestation.

R9-8-1323. Reserved
R9-8-1324. Reserved
R9-8-1325. Reserved
R9-8-1326. Reserved
R9-8-1327. Reserved
R9-8-1328. Reserved
R9-8-1329. Reserved
R9-8-1330. Reserved

R9-8-1331. Bedding
A. The beds, mattresses, pillows, and bed linen, including sheets, pillow slips, blankets, etc., used in all transient dwelling establishments shall be maintained in good repair, shall be kept clean and free of vermin, and shall be properly stored when not in use.
B. Each bed, bunk, cot, or other sleeping place shall be provided with pillow slips, under and top sheets for the use of guests. Sheets and pillow slips shall be adequately sized to completely cover the mattress and pillow.
C. Clean linen shall be provided to each new guest and shall be changed at least once each week when occupancy exceeds this period.

R9-8-1332. Food service
The storage, preparation and serving of food and drink shall comply with the requirements of Article 1 of this Chapter.

R9-8-1333. Drinking water; ice
A. Where drinking fountains are provided, the fountain shall be constructed so that the drinking is from a free jet projected at an angle from the vertical and provided with a guard to prevent the mouth being placed directly against the orifice. There shall be no possibility of the orifice becoming submerged. The fountain bowl shall be constructed of nonabsorbent, easily cleanable material.
B. All glasses and other multi-use utensils furnished to each dwelling unit shall be cleaned and sanitized in an approved manner after each occupancy. Single-service paper cups with suitable dispenser may be substituted for glasses.
C. The use of a common drinking cup is prohibited.
D. Ice shall be obtained from an approved source and shall be stored and handled in such a manner as to prevent contamination.

R9-8-1334. Refuse
A. All refuse shall be stored and disposed of in accordance with Article 4 of these regulations.
B. Garbage cans shall be thoroughly washed after emptying and shall be maintained free of odors and other objectionable conditions.
C. All containers for rubbish shall be cleaned as often as necessary to prevent a nuisance.
D. All refuse containers shall be maintained in good repair.

R9-8-1335. Water supply
Each transient dwelling establishment shall be provided with an adequate and safe water supply from an approved source. Whenever a transient dwelling establishment finds it necessary to develop a source or sources of supply, complete plans and specifications of the proposed water system shall be submitted to the Department and approval received prior to the start of construction. The design, construction, and operation of all such water supply systems shall comply with Article 2 of this Chapter.

R9-8-1336. Toilet; lavatory
A. Adequate and convenient toilet, lavatory, and bathing facilities shall be provided at all transient dwelling establishments and shall be available to the guests at all times.
B. Where private or connecting toilet rooms are not available for each dwelling unit, separate and plainly marked central toilet rooms for each sex shall be provided, located within 200 feet of such units.
C. Central toilet rooms shall provide not less than one toilet, one lavatory, and one tub or shower for each sex for each 10 dwelling units, or major faction thereof, not having private or connecting baths. At least one urinal shall be provided in each central toilet room designated for men.
D. Hot and cold water and soap shall be provided in all toilet rooms. Clean, individual sanitary towels shall be furnished for each guest.
E. Toilet rooms shall be well lighted and ventilated. Where gravity or mechanical ventilation is provided, the ventilation ducts for the toilet rooms shall not be connected into ventilation ducts from or to any dwelling unit.
F. Floors of all toilet rooms shall be of easily cleanable construction, shall be kept clean and in good repair, and where necessary shall slope to properly located drains.
G. Walls and ceilings of all toilet rooms shall be of easily cleanable construction and shall be kept clean and in good repair.

R9-8-1337. Sewage disposal
A. The liquid wastes from all transient dwelling establishments shall be discharged into a public sewer system in compliance with applicable local ordinances or codes or into separate sewage disposal facilities approved by the Department.
B. Separate sewage disposal facilities will not be approved where in the opinion of the Department connection to a public sewer is practicable.
C. Where separate sewage disposal facilities are proposed the design, construction and operation of such systems shall be in accordance with Article 3 of this Chapter. Plans and specifications for such systems shall be submitted to the Department and approval received prior to the start of construction.
D. Recommendations are found in the Engineering Bulletins of the Department to assist in compliance with these regulations regarding the design of sewage disposal systems. Copies of these Bulletins may be obtained from the Department.

E. No sewage treatment effluent or other wastewater shall be deposited on the surface of the ground except in a manner approved by the Department.

R9-8-1338. Plumbing

All plumbing shall be installed in accordance with any local ordinance or code. Where a local ordinance or code does not exist, plumbing shall be installed in accordance with the requirements adopted by reference in R9-1-412(D).

ARTICLE 14. REPEALED

Article 14, consisting of Sections R9-8-1411 thru R9-8-1413, repealed effective April 10, 1997 (Supp. 97-2).

R9-8-1411. Repealed

Historical Note
Repealed effective April 10, 1997 (Supp. 97-2).

R9-8-1412. Repealed

Historical Note
Repealed effective April 10, 1997 (Supp. 97-2).

R9-8-1413. Repealed

Historical Note
Repealed effective April 10, 1997 (Supp. 97-2).

ARTICLE 15. REPEALED

Article 15, consisting of Sections R9-8-1511 and R9-8-1512, repealed effective August 15, 1989 (Supp. 89-3).

ARTICLE 16. REPEALED

R9-8-1601. Reserved
R9-8-1602. Reserved
R9-8-1603. Reserved
R9-8-1604. Reserved
R9-8-1605. Reserved
R9-8-1606. Reserved
R9-8-1607. Reserved
R9-8-1608. Reserved
R9-8-1609. Reserved
R9-8-1610. Reserved
R9-8-1611. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1612. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1613. Reserved

R9-8-1614. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1615. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1616. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1617. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1618. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1619. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1620. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1621. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1622. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1623. Reserved

R9-8-1624. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1625. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1626. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1627. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1628. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1629. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1630. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1631. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1632. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-6-1633. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1634. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1635. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1636. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1637. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1638. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1639. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1640. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1641. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1642. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1643. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1644. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1645. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1646. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1647. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1648. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

R9-8-1649. Repealed

Historical Note
Adopted effective September 21, 1976 (Supp. 76-4).
Repealed effective October 9, 1998 (Supp. 98-4).

ARTICLE 17. RENUMBERED

See Title 18, Chapter 8, Article 4.

ARTICLE 18. RENUMBERED

See Title 18, Chapter 8, Article 2.

ARTICLE 19. EMERGENCY EXPIRED

Article 19 consisting of Sections R9-8-1901 through R19-8-1905 adopted as an emergency effective June 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Emergency expired. Language deleted (Supp. 87-2).

TITLE 9. HEALTH SERVICES

CHAPTER 9. DEPARTMENT OF HEALTH SERVICES
HEALTH CARE INSTITUTIONS: ESTABLISHMENT; MODIFICATION

ARTICLE 1. REPEALED

Article 1 consisting of Sections R9-9-01 through R9-9-18, R9-9-20 and R9-9-21 repealed as an emergency effective November 24, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days, now repealed effective March 24, 1981 (Supp. 81-2).

ARTICLE 2. REPEALED

Article 2, consisting of Sections R9-9-225 through R9-9-243, repealed by summary action, permanent effective date April 21, 1995 (Supp. 95-3).

Article 2, consisting of Sections R9-9-225 through R9-9-243, repealed by summary action interim effective date April 21, 1995 (Supp. 95-2).

Article 2 consisting of Sections R9-90-25 through R9-9-43 renumbered as Sections R9-9-225 through R9-9-243 (Supp. 81-2).

Section

R9-9-201. Reserved
R9-9-202. Reserved
R9-9-203. Reserved
R9-9-204. Reserved
R9-9-205. Reserved
R9-9-206. Reserved
R9-9-207. Reserved
R9-9-208. Reserved
R9-9-209. Reserved
R9-9-210. Reserved
R9-9-211. Reserved
R9-9-212. Reserved
R9-9-213. Reserved
R9-9-214. Reserved
R9-9-215. Reserved
R9-9-216. Reserved
R9-9-217. Reserved
R9-9-218. Reserved
R9-9-219. Reserved
R9-9-220. Reserved
R9-9-221. Reserved
R9-9-222. Reserved
R9-9-223. Reserved
R9-9-224. Reserved
R9-9-225. Repealed
R9-9-226. Repealed
R9-9-227. Repealed
R9-9-228. Repealed
R9-9-229. Repealed
R9-9-230. Repealed
R9-9-231. Repealed
R9-9-232. Repealed
R9-9-233. Repealed
R9-9-234. Repealed
R9-9-235. Repealed
R9-9-236. Repealed
R9-9-237. Repealed
R9-9-238. Repealed
R9-9-239. Repealed
R9-9-240. Repealed
R9-9-241. Repealed
R9-9-242. Repealed
R9-9-243. Repealed

ARTICLE 3. PERMIT FOR CONSTRUCTION OR MODIFICATION

R9-9-301. Reserved
R9-9-302. Reserved
R9-9-303. Reserved
R9-9-304. Reserved
R9-9-305. Reserved
R9-9-306. Reserved
R9-9-307. Reserved
R9-9-308. Reserved
R9-9-309. Reserved
R9-9-310. Reserved
R9-9-311. Scope
R9-9-312. Definitions
R9-9-313. Permit required
R9-9-314. Permit application
R9-9-315. Review of permit application
R9-9-316. Approval of application and issuance of permit
R9-9-317. Implementation of projects

ARTICLE 1. REPEALED

ARTICLE 2. REPEALED

R9-9-201. Reserved
R9-9-202. Reserved
R9-9-203. Reserved
R9-9-204. Reserved
R9-9-205. Reserved
R9-9-206. Reserved
R9-9-207. Reserved
R9-9-208. Reserved
R9-9-209. Reserved
R9-9-210. Reserved
R9-9-211. Reserved
R9-9-212. Reserved
R9-9-213. Reserved
R9-9-214. Reserved
R9-9-215. Reserved
R9-9-216. Reserved
R9-9-217. Reserved
R9-9-218. Reserved
R9-9-219. Reserved
R9-9-220. Reserved
R9-9-221. Reserved
R9-9-222. Reserved
R9-9-223. Reserved
R9-9-224. Reserved
R9-9-225. Repealed

Historical Note

Adopted effective July 29, 1975 (Supp. 75-1). Amended effective November 9, 1976 (Supp. 76-5). Amended effective March 24, 1981. Renumbered as Section R9-9-225 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-226. Repealed

Historical Note

Adopted effective July 29, 1975 (Supp. 75-1). Amended effective November 9, 1976 (Supp. 76-5). Former Section R9-9-26 repealed, new Section R9-9-26 adopted as an emergency effective August 14, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-4). Former Section R9-9-26 repealed, new Section R9-9-26 adopted as an emergency effective November 24, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-6). Former Section R9-9-26 as amended effective November 9, 1976, repealed, former Section R9-9-26 adopted as an emergency effective November 24, 1980, now adopted and amended effective March 24, 1981. Renumbered as Section R9-9-226 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-227. Repealed

Historical Note

Adopted effective July 29, 1975 (Supp. 75-1). Former Section R9-9-27 repealed, new Section R9-9-27 adopted effective November 9, 1976 (Supp. 76-5). Former Section R9-9-27 repealed, new Section R9-9-27 adopted as an emergency effective August 14, 1980, pursuant to A.R.S. § 41-103, valid for only 90 days (Supp. 80-4). Repealed as an emergency effective November 24, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-6). Former Section R9-9-27 adopted effective November 9, 1976, repealed, new Section R9-9-27 adopted effective March 24, 1981. Renumbered as Section R9-9-227 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-228. Repealed

Historical Note

Adopted effective July 29, 1975 (Supp. 75-1). Repealed as an emergency effective November 24, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days. Correction, Section *not* repealed (per notification by Attorney General dated December 29, 1980) error in certification effective November 24, 1980 (Supp. 80-6). Former Section R9-9-28 repealed, new Section R9-9-28 adopted effective March 24, 1981; renumbered as Section R9-9-228 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-229. Repealed

Historical Note

Adopted effective July 29, 1975 (Supp. 75-1). Former Section R9-9-29 repealed, new Section R9-9-29 adopted effective November 9, 1976 (Supp. 76-5). Former Section R9-9-29 repealed, new Section R9-9-29 adopted as an emergency effective August 14, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-4). Former Section R9-9-29 repealed, new Section R9-9-29 adopted as an emergency effective November 24, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-6). Former Section R9-9-29 adopted effective November 9, 1976 repealed, former Section R9-9-29 adopted as an emergency effective November 24, 1980 now adopted and amended effective March 24, 1981. Renumbered as Section R9-9-230 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-230. Repealed

Historical Note

Adopted effective July 29, 1975 (Supp. 75- 1). Former Section R9-9-30 repealed, new Section R9-9-30 adopted effective November 9, 1976 (Supp. 76-5). Former Section R9-9-30 repealed, new Section R9-9-30 adopted as an emergency effective August 14, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-4). Former Section R9-9-30 repealed, new Section R9-9-30 adopted as an emergency effective November 24, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-6). Former Section R9-9-30 adopted effective November 9, 1976 repealed, former Section R9-9-30 adopted as an emergency effective November 24, 1980 now adopted and amended effective March 24, 1981. Renumbered as Section R9-9-230 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-231. Repealed

Historical Note

Adopted effective July 29, 1975 (Supp. 75-1). Former Section R9-9-31 repealed, new Section R9-9-31 adopted effective November 9, 1976 (Supp. 76-5). Former Section R9-9-31 repealed, new Section R9-9-31 adopted as an emergency effective August 14, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-4). Former Section R9-9-31 repealed, new Section R9-9-31 adopted as an emergency effective November 24, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-6). Former Section R9-9-31 adopted effective November 9, 1976 repealed, former Section R9-9-31 adopted as an emergency effective November 24, 1980 now adopted and amended effective March 24, 1981. Renumbered as Section R9-9-231 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-232. Repealed

Historical Note

Adopted effective July 29, 1975 (Supp. 75-1). Former Section R9-9-32 repealed, new Section R9-9-32 adopted effective November 9, 1976 (Supp. 76-5). Former Section R9-9-32 repealed, new Section R9-9-32 adopted as an emergency effective August 14, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-4). Former Section R9-9-32 repealed, new Section R9-9-32 adopted as an emergency effective November 24, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-6). Former Section R9-9-32 adopted effective November 9, 1976, repealed, former Section R9-9-32 adopted as an emergency effective November 24, 1980, now adopted and amended effective March 24, 1981. Renumbered as Section R9-9-232 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-233. Repealed

Historical Note

Adopted effective July 29, 1975 (Supp. 75-1). Former Section R9-9-33 repealed, new Section R9-9-33 adopted effective November 9, 1976 (Supp. 76-5). Former Section R9-9-33 repealed, new Section R9-9-33 adopted as an emergency effective August 14, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-4). Former Section R9-9-33 repealed, new Section R9-9-33 adopted as an emergency effective November 24, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-6). Former Section R9-9-33 adopted effective November 9, 1976, repealed, former Section R9-9-33 adopted as an emergency now adopted and amended effective March 24, 1981. Renumbered as Section R9-9-233 (Supp. 81-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-234. Repealed

Historical Note

Adopted effective July 29, 1975 (Supp. 75-1). Former Section R9-9-34 repealed, new Section R9-9-34 adopted effective November 9, 1976 (Supp. 76-5). Former Section R9-9-34 repealed, new Section R9-9-34 adopted effective March 24, 1981. Renumbered as Section R9-9-234 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-235. Repealed

Historical Note

Adopted effective November 9, 1976 (Supp. 76-5). Former Section R9-9-35 repealed, former Section R9-9-36 adopted as an emergency effective November 24, 1980, renumbered and adopted as Section R9-9-35 effective March 24, 1981. Renumbered as Section R9-9-235 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-236. Repealed

Historical Note

Former Section R9-9-36 repealed, new Section R9-9-36 adopted as an emergency effective August 14, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-4). Correction, Historical Note for Supp. 80-4 should read "Adopted as an emergency effective August 14, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-4)". New Section R9-9-36 adopted as an emergency effective November 24, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-6). Former Section R9-9-36 adopted as an emergency effective November 24, 1980, renumbered as Section R9-9-35, former Section R9-9-37 adopted as an emergency effective November 24, 1980, renumbered and amended as Section R9-9-36 effective March 24, 1981. Renumbered as Section R9-9-236 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-237. Repealed

Historical Note

Former Section R9-9-37 repealed, new Section R9-9-37 adopted as an emergency effective August 14, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-4). Correction, Historical Note for Supp. 80-4 should read "Adopted as an emergency effective August 14, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-4)." New Section R9-9-37 adopted as an emergency effective November 24, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-6). Former Section R9-9-37 adopted as an emergency effective November 24, 1980, renumbered and adopted as Section R9-9-36, new Section R9-9-37 adopted effective March 24, 1981. Renumbered as Section R9-9-237 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-238. Repealed

Historical Note

Former Section R9-9-38 repealed, new Section R9-9-38 adopted as an emergency effective August 14, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-4). Correction, Historical Note for Supp. 80-4 should read "Adopted as an emergency effective August 14, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-4)." New Section R9-9-38 adopted as an emergency effective November 24, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-6). Former Section R9-9-38 adopted as an emergency effective November 24, 1980, renumbered and adopted as Section R9-8-39, new Section R9-9-38 adopted effective March 24, 1981. Renumbered as Section R9-9-238 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-239. Repealed

Historical Note

Former Section R9-9-39 repealed, new Section R9-9-39 adopted as an emergency effective August 14, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-4). Correction, Historical Note for Supp. 80-4 should read "Adopted as an emergency effective August 14, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-4)." New Section R9-9-39 adopted as an emergency effective November 24, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-6). Former Section R9-9-38 renumbered and adopted as Section R9-9-39 effective March 24, 1981. Renumbered as Section R9-9-239 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-240. Repealed

Historical Note

Former Section R9-9-40 repealed, new Section R9-9-40 adopted as an emergency effective August 14, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-4). Correction, Historical Note for Supp. 80-4 should read "Adopted as an emergency effective August 14, 1980, pursuant to A.R. S. § 41-1003, valid for only 90

days (Supp. 80-4)." New Section R9-9-40 adopted as an emergency effective November 24, 1990, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-6). New Section R9-9-40 adopted effective March 24, 1981. Renumbered as Section R9-9-240 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-241. Repealed

Historical Note
Amended effective August 21, 1975 (Supp. 75-1). Former Section R9-9-41 repealed, new Section R9-9-41 adopted as an emergency effective August 14, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-4). New Section R9-9-41 adopted as an emergency effective November 24, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-6). Former Section R9-9-41 adopted as an emergency effective November 24, 1980 renumbered and adopted as Section R9-9-43, new Section R9-9-41 adopted effective March 24, 1981. Renumbered as Section R9-9-241 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-242. Repealed

Historical Note
Adopted effective March 24, 1981. Renumbered as Section R9-9-242 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

R9-9-243. Repealed

Historical Note
Former Section R9-9-41 adopted as an emergency effective November 24, 1980, renumbered and adopted as Section R9-9-43 effective March 24, 1981. Renumbered as Section R9-9-243 (Supp. 81-2). Repealed by summary action interim effective date April 21, 1995 (Supp. 95-2). Summary rules repealed, permanent effective date April 21, 1995 (Supp. 95-3).

ARTICLE 3. PERMIT FOR CONSTRUCTION OR MODIFICATION

R9-9-301. Reserved

R9-9-302. Reserved

R9-9-303. Reserved

R9-9-304. Reserved

R9-9-305. Reserved

R9-9-306. Reserved

R9-9-307. Reserved

R9-9-308. Reserved

R9-9-309. Reserved

R9-9-310. Reserved

R9-9-311. Scope

A. This Article contains the requirements for submittal of an application for, and issuance by the Director of, a permit for the construction or modification of a health care institution as provided for in A.R.S. § 36-421.

B. Outpatient treatment clinics which have been granted a certificate of need, are exempted from the requirements of this Article by A.R.S. § 36-421.01. An outpatient treatment clinic is defined as a facility in which practitioners of the healing arts licensed under A. R. S. Title 32 practice, patients are not kept overnight and are not treated under general anesthesia.

Historical Note
Adopted effective February 15, 1978 (Supp. 78-1). Amended effective March 24, 1981 (Supp. 81-2).

R9-9-312. Definitions

Words defined in A.R.S. § 36-401 and R9-9-226 have the same meaning when used in this Article. In addition, unless the context otherwise requires:

1. "Architectural plans and specifications" means schematics, preliminary and final working drawings and specifications.
2. "Begin construction" means to initiate action at the project site to implement the construction documents to work order.
3. "Improvements of a minor nature" means modifications which are not substantial.
4. "Substantial" when used in connection with a modification means:
   a. Any change in bed capacity or the use of one or more existing beds, or
   b. For a modification involving services, that the modification of services will result in increased annual operating costs of $75,000 or more within twelve months of the date of the modification, or
   c. For a modification involving a move in the location at which a service is provided, that the move will entail a change of the address at which the service is provided, or
   d. For other modifications except as provided in subparagraph (e), that the cost of the modification is in excess of $150,000, or
   e. For a modification involving a change in the physical plant of the institution not covered by subparagraph (d), that the change will affect compliance with any applicable code or standard for licensure.

Historical Note
Adopted effective February 15, 1978 (Supp. 78-1). Amended effective March 24, 1981 (Supp. 81-2).

R9-9-313. Permit required

A. A permit is required pursuant to A.R.S. § 36-421 under the following circumstances:
   1. Construction of a health care institution or facilities therefor, and
   2. Modification, i.e., substantial improvement, enlargement, reduction, moving, alteration of, addition to, or other change in
      a. A health care institution,
      b. The facilities of a health care institution, or
      c. The services provided by a health care institution.

B. All applications for a permit shall be on, or in accordance with, forms supplied by the Department.

C. If a certificate of need is required for the project, the permit application must be filed with the Department prior to the expiration of the certificate of need.

Historical Note
Adopted effective February 15, 1978 (Supp. 78-1).

R9-9-314. Permit application

Each permit application when complete shall contain the following information:

1. Architectural plans and specifications, if the application involves construction work, provided however that this requirement may be waived by the Director for improvements of a minor nature. Such plans and specifications shall include:
   a. Materials specifications.
   b. Information concerning occupancy group, location on property, floor area, height of building, number of stories and projected occupant load.
   c. Scale drawings of each floor which show the relationship of the various departments or services to each other and their room arrangements.
   d. Finish grades, roads, walks, service drives, entrance courts, and parking and orientation.
   e. A cross-section indicating materials and type of construction.
   f. Approximate square footage of the proposed project and of each functional area and the resulting total for each department or major division of the institution.
   g. Electrical, mechanical, plumbing, fire protection and internal communications system.
   h. Estimated construction costs or a revision and update of any estimate previously submitted.
2. Evidence that the proposed construction or modification meets the minimum standards for licensure within the class or subclass of health care institution for which it is intended.
3. Evidence that applicant has or is able to obtain all approvals and consents required from other state and local governmental agencies, including information about applicant's compliance with planning, zoning, building and fire protection requirements.
4. Evidence that applicant has adequate financial resources to successfully undertake the proposed construction or modification and properly staff, equip and operate it after completion.
5. Evidence of the existence of a currently valid certificate of need which has been issued by the Director pursuant to A.R.S. § 36-433 et seq., if applicable.

Historical Note

Adopted effective February 15, 1978 (Supp. 78-1).
Amended effective March 24, 1981 (Supp. 81-2).

R9-9-315. Review of permit application

A. It is expected that the initial portion of the permit application for construction projects will be submitted before final details of required information, such as final working drawings and specifications, become available. The Department will work with the applicant during the review process to determine the depth of detail necessary to meet the requirements of this Article. A time schedule for submittal of all required information will be determined by the Department after conferring with the applicant based upon the scope and complexity of the project. If there are deficiencies in any part of the permit application, the Department will notify the applicant as soon as possible and make arrangements for informal meetings with the applicant or his representative to discuss revisions and, if necessary, submittal of additional information.

B. Preliminary drawings and outline specifications should be submitted for review and approval within the time schedule established and in accordance with the following:

1. Working drawings and specifications shall be drawn to scale and shall be of sufficient clarity to indicate the nature and extent of the work proposed and show in detail that it will conform to applicable provisions of the codes adopted by reference in R9-1-412 and all relevant laws, regulations, ordinances and rules. Drawings shall be prepared for each of the following branches of work: architectural, structural, mechanical, plumbing, electrical and fire protection.
2. Specifications shall fully describe types, sizes, capacities, workmanship, finishes and other characteristics of all materials and fixed equipment.
3. Estimates shall show in convenient form and detail the probable total cost of the work to be performed under the contract and fixed equipment contemplated by drawings and specifications.
4. Estimated date of completion of project shall be included and, if phased construction is contemplated, the completion date of each phase of the project.
5. Final bid documents shall comply with these regulations or with local building codes and ordinances, whichever is more restrictive.
6. Drawings of sprinkler, fire alarm, smoke detector, and chemical extinguishing systems shall show evidence of approval by the local fire protection agency. Permits will not be issued prior to receipt of such evidence of approval.
7. Final construction documents submitted to the Department shall be certified in accordance with A.R.S. Title 32, Chapter 1.

C. In the case of construction projects employing the "fast-track" method of construction, the Director may issue a separate permit for each stage of construction prior to submittal of all final working drawings and specifications if:

1. The application is otherwise complete and in order, and
2. The applicant agrees to submit such documents for review and approval in stages as they become available but in any event prior to beginning construction of the stage of the project to which each set of drawings and specifications applies.

Historical Note

Adopted effective February 15, 1978 (Supp. 78-1).

R9-9-316. Approval of application and issuance of permit

A. If the Director finds that the applicant has satisfied all applicable requirements of this Article, he will approve the application and issue the permit, otherwise he will deny the application. A decision on the application will be rendered within 60 days after all required information is received by the Department.

B. If the application is denied, the applicant will be given written notification of denial and may then request a hearing pursuant to A.R.S. § 36-428.

C. Except as provided in subsection (D), a permit shall be valid for a period of 120 days from its date of issuance and, thereafter, as long as the permit holder continues work on the project, unless the certificate of need authorizing the project is withdrawn by the Department pursuant to A.R.S. § 36-433.02(B). Should the certificate be withdrawn, the permit shall also be considered void.

D. If applicant is unable to begin construction within 120 days due to causes beyond his control, the Director may grant an extension of time provided the applicant files a written request for extension with sufficient information to indicate that the inability to begin construction is due to a cause or causes beyond the applicant's control and there was no contributory fault or negligence on the applicant's part.

Historical Note
Adopted effective February 15, 1978 (Supp. 78-1).
Amended subsection (C) effective March 24, 1981 (Supp. 81-2).

R9-9-317. Implementation of projects

A. All projects shall be implemented in conformance with the project description, schedule and other conditions of the permit. Implementation may begin immediately upon receipt of the permit.

B. On construction projects, applicant shall begin construction within 120 days following receipt of the permit or within such longer period as may be approved under R9-9-316.

C. All construction shall be in accordance with the approved final drawings and specifications. If it is desired to make deviations from the approved drawings or specifications not involving a change of services, the Department shall be notified and the owner may proceed with the change either before or after notification. If approval is subsequently denied, it is the responsibility of the permit holder to correct such change to conform to the approved drawings or to conform to an alternate approved by the Department. If deviation from an approved drawing or specification would result in a change of services, such change may require a new certificate of need or a new permit or both.

D. All construction shall be completed on or before the completion deadline specified in the permit unless a written extension is obtained from the Director.

E. The following documents shall be filed with the Department promptly after completion of the project:

1. If available, a copy of the certificate of occupancy issued by the appropriate local authority, or other satisfactory evidence that completion of the project was accomplished according to the architectural plans and specifications.
2. A final cost report which lists to the extent applicable, the cost of construction, fixed equipment, movable equipment, site survey and soil investigation, architect and consultant fees, supervision and inspection at site, legal fees and financing fees.

Historical Note
Adopted effective February 15, 1978 (Supp. 78-1).

TITLE 9. HEALTH SERVICES

CHAPTER 10. DEPARTMENT OF HEALTH SERVICES
HEALTH CARE INSTITUTIONS: LICENSURE

Editor's Note: This Chapter contains rules which were adopted, amended, and repealed under exemptions from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to Laws 1993, Ch. 163, § 3(B); Laws 1996, Ch. 329, § 5; and Laws 1998, Ch. 178 § 17. Exemption from A.R.S. Title 41, Chapter 6 means that the Department of Health Services did not submit these rules to the Governor's Regulatory Review Council for review; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is being printed on blue paper.

ARTICLE 1. GENERAL

Section

R9-10-101. Reserved
R9-10-102. Reserved
R9-10-103. Reserved
R9-10-104. Reserved
R9-10-105. Reserved
R9-10-106. Reserved
R9-10-107. Reserved
R9-10-108. Reserved
R9-10-109. Reserved
R9-10-110. Reserved
R9-10-111. Legal authority
R9-10-112. Intent and purpose of this Article
R9-10-113. Definitions
R9-10-114. Classifications
R9-10-115. Unclassified health care institutions
R9-10-116. Documentation
R9-10-117. Transfer to another subclass
R9-10-118. Reserved
R9-10-119. Reserved
R9-10-120. Reserved
R9-10-121. General requirements for licensure
R9-10-122. Reserved
R9-10-123. Initial application
R9-10-124. Renewal application

ARTICLE 2. GENERAL HOSPITALS

Article 2, consisting of Sections R9-10-201 through R9-10-233, adopted effective February 23, 1979.

Former Article 2, consisting of Sections R9-10-201 through R9-10-250, renumbered as Sections R9-10-301 through R9-10-335 as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days.

Section

R9-10-201. Reserved
R9-10-202. Reserved
R9-10-203. Reserved
R9-10-204. Reserved
R9-10-205. Reserved
R9-10-206. Reserved
R9-10-207. Reserved
R9-10-208. Reserved
R9-10-209. Reserved
R9-10-210. Reserved
R9-10-211. General
R9-10-212. Definitions
R9-10-213. Administration
R9-10-214. Medical staff
R9-10-215. Nursing services
R9-10-216. Surgical services
R9-10-217. Dietetic services
R9-10-218. Emergency services
R9-10-219. Disaster preparedness
R9-10-220. Environmental services
R9-10-221. Medical records services
R9-10-222. Laboratory services
R9-10-223. Pharmaceutical services
R9-10-224. Rehabilitation services
R9-10-225. Quality assurance
R9-10-226. Radiology services
R9-10-227. Respiratory care services
R9-10-228. Special care units
R9-10-229. Obstetrical services
R9-10-230. Pediatric services
R9-10-231. Social services
R9-10-232. Hospital physical plant
R9-10-233. Rates and charges

ARTICLE 3. RURAL GENERAL HOSPITALS

Article 3, consisting of Sections R9-10-301 through R9-10-333, adopted effective February 4, 1981.

Former Article 3, consisting of Sections R9-10-301 through R9-10-335, repealed effective February 4, 1981.

Section

R9-10-301. Reserved
R9-10-302. Reserved
R9-10-303. Reserved
R9-10-304. Reserved
R9-10-305. Reserved
R9-10-306. Reserved
R9-10-307. Reserved
R9-10-308. Reserved
R9-10-309. Reserved
R9-10-310. Reserved
R9-10-311. General
R9-10-312. Definitions
R9-10-313. Administration
R9-10-314. Medical staff
R9-10-315. Nursing services
R9-10-316. Surgical services
R9-10-317. Dietetic services
R9-10-318. Emergency services
R9-10-319. Disaster preparedness
R9-10-320. Environmental services
R9-10-321. Medical records services
R9-10-322. Laboratory services
R9-10-323. Pharmaceutical services
R9-10-324. Rehabilitation services
R9-10-325. Quality assurance
R9-10-326. Radiology services
R9-10-327. Respiratory care services
R9-10-328. Special care units
R9-10-329. Obstetrical services
R9-10-330. Pediatric services
R9-10-331. Social services
R9-10-332. Rural general hospital physical plant

R9-10-333. Rates and charges
R9-10-334. Reserved
R9-10-335. Reserved

ARTICLE 4. SPECIAL HOSPITALS

Section
R9-10-401. Reserved
R9-10-402. Reserved
R9-10-403. Reserved
R9-10-404. Reserved
R9-10-405. Reserved
R9-10-406. Reserved
R9-10-407. Reserved
R9-10-408. Reserved
R9-10-409. Reserved
R9-10-410. Reserved
R9-10-411. General
R9-10-412. Definitions
R9-10-413. Administration
R9-10-414. Medical staff
R9-10-415. Nursing services
R9-10-416. Surgical services
R9-10-417. Dietetic services
R9-10-418. Emergency services
R9-10-419. Disaster preparedness
R9-10-420. Environmental services
R9-10-421. Medical records
R9-10-422. Laboratory services
R9-10-423. Pharmaceutical services
R9-10-424. Rehabilitation services
R9-10-425. Quality assurance
R9-10-426. Radiology services
R9-10-427. Respiratory care service
R9-10-428. Special care units
R9-10-429. Obstetrical services
R9-10-430. Pediatric services
R9-10-431. Social services
R9-10-432. Hospital physical plant
R9-10-433. Rates and charges
R9-10-434. License application
R9-10-435. Special hospitals that limit admission to patients requiring pain and stress services
R9-10-436. Special hospitals that limit admission to patients requiring psychiatric services
R9-10-437. Special hospitals limiting admissions to patients requiring services in rehabilitation medicine
R9-10-438. Special hospitals limiting admissions to patients requiring substance abuse services
R9-10-439. Repealed

ARTICLE 5. ADULT DAY HEALTH CARE FACILITIES

Article 5, consisting of Sections R9-10-501 through R9-10-514, adopted effective April 4, 1994 (Supp. 94-2).

Article 5, consisting of Sections R9-10-501 through R9-10-518, repealed effective April 4, 1994 (Supp. 94-2).

Article 5, consisting of Sections R9-10-501 through R9-10-518, adopted as permanent rules effective October 30, 1989.

Article 5, consisting of Sections R9-10-501 through R9-10-518, readopted as an emergency effective July 31, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

Article 5, consisting of Sections R9-10-501 through R9-10-518, readopted as an emergency effective April 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

Article 5, consisting of Sections R9-10-501 through R9-10-518, readopted as an emergency effective January 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

New Article 5, consisting of Sections R9-10-501 through R9-10-518, adopted as an emergency effective October 26, 1988 pursuant to A.R.S. § 41-1026, valid for only 90 days. Emergency expired.

Former Article 5, consisting of Sections R9-10-501 through R9-10-574, repealed effective October 20, 1982.

Section
R9-10-501. Definitions
R9-10-502. Administration
R9-10-503. Personnel
R9-10-504. Staffing
R9-10-505. Participant Rights
R9-10-506. Participants' Council
R9-10-507. Enrollment
R9-10-508. Discharge
R9-10-509. Adult Day Health Services
R9-10-510. Care Plan
R9-10-511. Participant Records
R9-10-512. Physical Plant Requirements
R9-10-513. Environmental Standards
R9-10-514. Safety Standards
R9-10-515. Repealed
R9-10-516. Repealed
R9-10-517. Repealed
R9-10-518. Repealed

ARTICLE 6. REPEALED

Article 6, consisting of Sections R9-10-611 through R9-10-624, repealed effective November 1, 1998, under an exemption from the Administrative Procedure Act; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

ARTICLE 7. ASSISTED LIVING FACILITIES

Article 7, consisting of Sections R9-10-701 through R9-7-710, repealed; New Article 7, consisting of Sections R9-10-701 through R9-7-724 adopted; both actions effective November 1, 1998 under an exemption from the Administrative Procedure Act; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Article 7, consisting of Sections R9-10-701 through R9-10-710, adopted as permanent rules effective October 30, 1989.

Article 7, consisting of Sections R9-10-701 through R9-10-710, readopted as an emergency effective July 31, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

Article 7, consisting of Sections R9-10-701 through R9-10-710, readopted as an emergency effective April 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

Article 7, consisting of Sections R9-10-701 through R9-10-710, readopted as an emergency effective January 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

New Article 7, consisting of Sections R9-10-701 through R9-10-710, adopted as an emergency effective October 26, 1988 pursuant to A.R.S. § 41-1026, valid for only 90 days. Emergency expired.

Former Article 7, consisting of Sections R9-10-701 through R9-10-737, repealed effective October 20, 1982.

Section
R9-10-701. Definitions
R9-10-702. Licensing Classifications
R9-10-703. Administration
R9-10-704. Abuse, Neglect, and Exploitation Prevention and Reporting

R9-10-705. Limitations on Level of Services
R9-10-706. Personnel Qualifications and Records
R9-10-707. Employee Orientation and Ongoing Training
R9-10-708. Personnel Requirements
R9-10-709. Residency Agreements
R9-10-710. Resident Rights
R9-10-711. Requirements for Service Plans and Health-Related Services
R9-10-712. Activity Programs
R9-10-713. Medications
R9-10-714. Resident Records
R9-10-715. Food Services
R9-10-716. Physical Plant Requirements
R9-10-717. Fire and Safety Requirements
R9-10-718. Environmental Services
R9-10-719. Supplemental Requirements for an Assisted Living Home
R9-10-720. Supplemental Requirements for an Assisted Living Center
R9-10-721. Supplemental Requirements for an Assisted Living Facility Licensed to Provide Supervisory Care Services
R9-10-722. Supplemental Requirements for an Assisted Living Facility Licensed to Provide Personal Care Services
R9-10-723. Supplemental Requirements for an Assisted Living Facility Licensed to Provide directed Care Services
R9-10-724. Supplemental Requirements for Training Programs

ARTICLE 8. HOSPICES

Article 8 (Sections R9-10-801 through R9-10-812) adopted as permanent rules effective October 30, 1989.

Article 8, consisting of Sections R9-10-801 through R9-10-812, readopted as an emergency effective July 31, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

Article 8, consisting of Sections R9-10-801 through R9-10-812, readopted as an emergency effective April 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

Article 8, consisting of Sections R9-10-801 through R9-10-812, readopted as an emergency effective January 27, 1989 pursuant to A.R.S. § 41-1026, valid for only 90 days.

New Article 8, consisting of Sections R9-10-801 through R9-10-812, adopted as an emergency effective October 26, 1988 pursuant to A.R.S. § 41-1026, valid for only 90 days. Emergency expired.

Former Article 8, consisting of Sections R9-10-801 through R9-10-867, repealed effective October 20, 1982.

Section
R9-10-801. Definitions
R9-10-802. General requirements
R9-10-803. Administration
R9-10-804. Medical advisor
R9-10-805. Policies and procedures
R9-10-806. Admissions
R9-10-807. Patient care plan
R9-10-808. Hospice services
R9-10-809. Clinical record
R9-10-810. Quality assurance
R9-10-811. Inpatient services requirements
R9-10-812. Variances

ARTICLE 9. NURSING CARE INSTITUTIONS

Article 9, consisting of Sections R9-10-901 through R9-10-917 adopted effective February 17, 1995 (Supp. 95-1).

Article 9, consisting of Sections R9-10-911 through R9-10-925, repealed effective February 17, 1995 (Supp. 95-1).

Article 9, consisting of Sections R9-10-911 through R9-10-925, adopted effective October 20, 1982 (Supp. 82-5).

Section
R9-10-901. Definitions
R9-10-902. Administration
R9-10-903. Personnel
R9-10-904. Staffing
R9-10-905. Nursing Services
R9-10-906. Resident Rights
R9-10-907. Admissions
R9-10-908. Transfers or Discharges
R9-10-909. Service Standards
R9-10-910. Medications
R9-10-911. Food Services
R9-10-912. Resident Records
R9-10-913. Physical Plant Standards
R9-10-914. Environmental Standards
R9-10-915. Safety Standards
R9-10-916. Quality Management
R9-10-917. Quality Rating
R9-10-918. Repealed
R9-10-919. Repealed
R9-10-920. Repealed
R9-10-921. Repealed
R9-10-922. Repealed
R9-10-923. Repealed
R9-10-924. Repealed
R9-10-925. Repealed

ARTICLE 10. REPEALED

Article 10, consisting of Sections R9-10-1011 through R9-10-1030, repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

The proposed summary action repealing R9-10-1011 through R9-10-1030 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rules. Sections in effect before the proposed summary action have been restored (Supp. 97-1).

Article 10, consisting of R9-10-1011 through R9-10-1030, repealed by summary action, interim effective date of July 21, 1995.

Section
R9-10-1001. Reserved
R9-10-1002. Reserved
R9-10-1003. Reserved
R9-10-1004. Reserved
R9-10-1005. Reserved
R9-10-1006. Reserved
R9-10-1007. Reserved
R9-10-1008. Reserved
R9-10-1009. Reserved
R9-10-1010. Reserved
R9-10-1011. Repealed
R9-10-1012. Repealed
R9-10-1013. Repealed
R9-10-1014. Repealed
R9-10-1015. Repealed
R9-10-1016. Repealed
R9-10-1017. Repealed
R9-10-1018. Repealed
R9-10-1019. Repealed
R9-10-1020. Repealed
R9-10-1021. Repealed
R9-10-1022. Repealed

R9-10-1023. Repealed
R9-10-1024. Repealed
R9-10-1025. Repealed
R9-10-1026. Repealed
R9-10-1027. Repealed
R9-10-1028. Repealed
R9-10-1029. Repealed
R9-10-1030. Repealed

ARTICLE 11. HOME HEALTH AGENCIES

Article 11, consisting of Sections R9-10-1101 through R9-10-1109 adopted effective July 22, 1994 (Supp. 94-3).

Article 11, consisting of Sections R9-10-1111 through R9-10-1127 repealed effective July 22, 1994 (Supp. 94-3).

Section
R9-10-1101. Definitions
R9-10-1102. Administration
R9-10-1103. Personnel
R9-10-1104. Home Health Services
R9-10-1105. Supportive Services
R9-10-1106. Plan of Care
R9-10-1107. Patient Rights
R9-10-1108. Medical Records
R9-10-1109. Quality Management
R9-10-1110. Reserved
R9-10-1111. Repealed
R9-10-1112. Repealed
R9-10-1113. Repealed
R9-10-1114. Repealed
R9-10-1115. Repealed
R9-10-1116. Repealed
R9-10-1117. Repealed
R9-10-1118. Repealed
R9-10-1119. Repealed
R9-10-1120. Repealed
R9-10-1121. Repealed
R9-10-1122. Repealed
R9-10-1123. Repealed
R9-10-1124. Repealed
R9-10-1125. Repealed
R9-10-1126. Repealed
R9-10-1127. Repealed

ARTICLE 12. INFIRMARY

Article 12, consisting of Sections R9-10-1201 through R9-10-1230, adopted effective February 4, 1981.

Section
R9-10-1201. Reserved
R9-10-1202. Reserved
R9-10-1203. Reserved
R9-10-1204. Reserved
R9-10-1205. Reserved
R9-10-1206. Reserved
R9-10-1207. Reserved
R9-10-1208. Reserved
R9-10-1209. Reserved
R9-10-1210. Reserved
R9-10-1211. General
R9-10-1212. Definitions
R9-10-1213. Administration
R9-10-1214. Medical staff
R9-10-1215. Nursing services
R9-10-1216. Surgical services
R9-10-1217. Dietetic services
R9-10-1218. Emergency services
R9-10-1219. Disaster preparedness
R9-10-1220. Environmental services
R9-10-1221. Medical records services
R9-10-1222. Laboratory services
R9-10-1223. Pharmaceutical services
R9-10-1224. Rehabilitation services
R9-10-1225. Reserved
R9-10-1226. Radiology services
R9-10-1227. Respiratory care services
R9-10-1228. Obstetrical services
R9-10-1229. Reserved
R9-10-1230. Physical plant construction standards

ARTICLE 13. REPEALED

Article 13, consisting of Sections R9-10-1301 through R9-10-1314, repealed effective November 1, 1998, under an exemption from the Administrative Procedure Act; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Article 13, consisting of Sections R9-10-1301 through R9-10-1314, adopted as permanent rules effective November 25, 1992 (Supp. 92-4).

Article 13, consisting of Sections R9-10-1301 through R9-10-1314, adopted again as an emergency effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3).

Article 13, consisting of Sections R9-10-1301 through R9-10-1314, adopted again as an emergency effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2).

Article 13, consisting of Sections R9-10-1301 through R9-10-1314, adopted again as an emergency effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1).

Article 13, consisting of Sections R9-10-1301 through R9-10-1314, adopted as an emergency effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4).

Article 13, consisting of Sections R9-10-1301 through R9-10-1306, adopted as an emergency effective March 29, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-1). Emergency expired.

ARTICLE 14. RECOVERY CARE CENTERS

Article 14, consisting of Sections R9-10-1401 through R9-10-1412, adopted effective February 1, 1994 (Supp. 94-1).

Section
R9-10-1401. Definitions
R9-10-1402. Administration
R9-10-1403. Patient Rights
R9-10-1404. Personnel
R9-10-1405. Nursing Services
R9-10-1406. Admissions
R9-10-1407. Ancillary Services
R9-10-1408. Quality Management
R9-10-1409. Medical Records
R9-10-1410. Environmental Standards
R9-10-1411. Emergency Standards
R9-10-1412. Physical Plant Requirements

ARTICLE 15. REPEALED

Article 15, consisting of Sections R9-10-1501 through R9-10-1514, repealed effective November 1, 1998, under an exemption from the Administrative Procedure Act; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

ARTICLE 16. RESERVED

ARTICLE 17. OUTPATIENT SURGICAL CENTERS

Article 17, consisting of Sections R9-10-1701 through R9-10-1713, adopted effective July 6, 1994 (Supp. 94-3).

Article 17, consisting of Sections R9-10-1711 through R9-10-1713, R9-10-1715 through R9-10-1723, and R9-10-1731 through R9-10-1734, repealed effective July 6, 1994 (Supp. 94-3).

Section

R9-10-1701. Definitions
R9-10-1702. Administration
R9-10-1703. Patient Rights
R9-10-1704. Personnel
R9-10-1705. Medical Staff
R9-10-1706. Nursing Services
R9-10-1707. Admission
R9-10-1708. Quality Management
R9-10-1709. Surgical Services Requirements
R9-10-1710. Medical Records
R9-10-1711. Environmental Standards
R9-10-1712. Emergency Standards
R9-10-1713. Physical Plant Standards
R9-10-1714. Reserved
R9-10-1715. Repealed
R9-10-1716. Repealed
R9-10-1717. Repealed
R9-10-1718. Repealed
R9-10-1719. Repealed
R9-10-1720. Repealed
R9-10-1721. Repealed
R9-10-1722. Repealed
R9-10-1723. Repealed
R9-10-1724. Reserved
R9-10-1725. Reserved
R9-10-1726. Reserved
R9-10-1727. Reserved
R9-10-1728. Reserved
R9-10-1729. Reserved
R9-10-1730. Reserved
R9-10-1731. Repealed
R9-10-1732. Repealed
R9-10-1733. Repealed
R9-10-1734. Repealed

ARTICLE 1. GENERAL

R9-10-101. Reserved

R9-10-102. Reserved

R9-10-103. Reserved

R9-10-104. Reserved

R9-10-105. Reserved

R9-10-106. Reserved

R9-10-107. Reserved

R9-10-108. Reserved

R9-10-109. Reserved

R9-10-110. Reserved

R9-10-111. Legal authority

The Arizona State Department of Health, pursuant to the authority granted in Title 36, Chapter 4 and pertinent paragraphs of A.R.S. § 36-136(G) adopts the rules, regulations and standards contained in Chapter 10 for the licensing and regulation of health care institutions.

Historical Note

Amended effective February 4, 1981 (Supp. 81-1).

R9-10-112. Intent and purpose of this Article

A. Health care institutions provide services ranging from medical and specialized care to health related services only. The units within this institutional spectrum are classified in R9-10-114 in accordance with the range and depth of services and care, the qualifications of staff and the physical plant and equipment. Classification of patients among the classes or subclasses of health care institutions is determined by the care needed by the patient. In institutions other than general hospitals, it is the responsibility of the governing body and the administrator to accept only those patients whose needs do not exceed the specialty or range of services for which the institution is licensed.

B. It is the objective of the Director, in the adoption of the regulations in this Chapter:

1. To provide each institution latitude for maximum utilization of medical and paramedical manpower and the sharing of central services to the extent consistent with good health care and to encourage all institutions to use interinstitutional and outside service agreements, where appropriate, in lieu of unnecessary duplication of services at each facility.
2. To establish minimum standards for personnel, facilities, services, policies, procedures and records.
3. To assure that each patient is placed in an institution qualified to provide the care his needs may require.
4. To promote the establishment of innovative methods and activities to reduce the cost and improve the quality of health care. To that end, the Department intends to temper the uniform application of regulations in this Chapter with intelligent discretion. It is not intended that the application of this Paragraph would permit the relaxation of standards, but rather, the use of alternate methods for efficiently achieving equal or higher standards.

Historical Note

Amended effective February 4, 1981 (Supp. 81-1).

R9-10-113. Definitions

A. Words defined in A.R.S. § 36-401 have the same meaning when used in this Chapter except "residential care institution", "supervisory care services", and "facilities" which are otherwise defined in Subsection (B). The following statutory definitions are noted:

1. "Adaptive services" means medical services provided on an outpatient basis.
2. "Ambulatory person" means any individual, including one who uses a cane or other ambulatory support device, who is physically and mentally capable under emergency conditions of finding a way to safety without assistance.
3. "Construction" means the building, erection, fabrication, or installation of a health care institution of facilities therefor.
4. "Department" means the Department of Health Services.
5. "Direction" means authoritative policy or procedural guidance for the accomplishment of a function or activity.
6. "Director" means the Director of the Department of Health Services.
7. "Governing authority" means the individual, agency, group or corporation, appointed, elected or otherwise des-

ignated, in which the ultimate responsibility and authority for the conduct of the health care institution is vested.

8. "Health care institution" means every place, institution, building or agency, whether organized for profit or not, which provides facilities with medical services, nursing services, health-related services or supervisory care services.
9. "Health related services" means services, other than medical, pertaining to general supervision, protective, preventive and personal care services or supervisory care services.
10. "Inpatient beds" or "resident beds" means accommodations, with supporting services such as food, laundry and housekeeping, for patients or residents who generally stay in excess of 24 hours.
11. "Medical services" means the services pertaining to medical care that are performed at the direction of a physician in behalf of patients by physicians, dentists, nurses and other professional and technical personnel.
12. "Modification" means the substantial improvement, enlargement, reduction, moving or alteration of, addition to, or other change in a health care institution or its facilities or in the services provided by such an institution.
13. "Nursing care institution" means a health care institution providing inpatient beds or resident beds and nursing services to persons who need nursing services on a continuing basis but who do not require hospital care or direct daily care from a physician.
14. "Physician" means any person licensed under provisions of A.R.S. Title 32, Chapter 13 and 17.
15. "Supervision" means direct overseeing and inspection of the act of accomplishing a function or activity.
16. "Supervisory care home" means a residential care institution, which provides only supervisory care services to more than five ambulatory persons unrelated to the administrator or owner of such home.

B. In this Chapter, unless the context otherwise requires:

1. "Ancillary nursing personnel" means persons employed to assist registered nurses or licensed practical nurses in the care of patients. This term does not include clerical personnel or volunteers.
2. "Audiologist" means a person who has been granted a Certificate of Clinical Competence in audiology by the American Speech and Hearing Association, or who has completed the equivalent educational requirements and work experience necessary for such a certificate, or who has completed the academic program and is in the process of accumulating the supervised work experience required to qualify for such a certificate.
3. "Behavioral health service" means screening, evaluation, care or treatment services to prevent, reduce, or eliminate substance abuse and the behavioral disorders related to 1 or more mental or emotional problems or to substance abuse.
4. "Behavioral health service agency" means a class of health care institution other than a hospital which provides screening, evaluation, care or treatment to persons having behavioral disorders related to a mental or emotional problem(s) or substance abuse.
5. "Dietitian" means a person who meets the standards of qualifications established by the Commission on Dietetic Registration under the requirements in effect on or prior to March 9, 1976, or who has completed the equivalent education requirements and work experience necessary for such registration or who has completed the academic program and is in the process of accumulating the supervised work experience required to qualify for such registration.
6. "Director of nursing" means a registered nurse with supervisory and administrative ability who is responsible to the chief administrative officer for direction of nursing service for the entire facility for all shifts.
7. "Drug administration" means the giving of a single dose of medication to a specific patient as a result of an order of a physician or other authorized medical practitioner.
8. "Drug dispensing" means the issuing of 1 or more doses of a medication in a suitable container with appropriate label for subsequent administration to or use by a patient.
9. "Emergency treatment clinic" is a subclass of outpatient treatment center with facilities and limited hospital services for the physical evaluation of outpatients and having as its principal service the initial care of injuries or illnesses.
10. "Facilities", except where used in the name of a class or subclass, is synonymous with health care institution as defined in A.R.S. § 36-401 and includes all places, institutions and services subject to A.R.S. Title 36, Chapter 4, Articles 1 and 2.
11. "Health services clinic" is a subclass of outpatient treatment center which provides adaptive services and where patients are not kept overnight as bed patients or treated under general anesthesia.
12. "Hospital services" means the pre-admission, outpatient, inpatient and post-discharge care provided in or by a general hospital, special hospital, rural general hospital or infirmary.
13. "Infirmary" is a class of health care institution having 30 or less inpatient beds and providing limited hospital services to the staff and students of a school, the members of an association or the clients or wards of a public agency.
14. "Institution", except where used in the name of a class or subclass, is synonymous with health care institution as defined in A.R.S. § 36-401 and includes all places, facilities and services subject to A.R.S. Title 36, Chapter 4, Articles 1 and 2.
15. "Intermediate care facility" means a subclass of nursing care institution which provides nursing and health-related services to patients as specified in R9-10-913.
16. "Licensed bed" means an individual patient care unit including a bed and related furniture, equipment and space.
17. "Licensed nursing personnel" means registered and licensed practical nurses.
18. "Medical staff" means physicians, dentists and other practitioners of the healing arts who have been granted privileges by agreement with the institution as defined in the institution's medical staff by-laws.
19. "New construction" means new buildings, addition to existing buildings, conversion of existing buildings or portions thereof or portions of buildings undergoing modification other than repair.
20. "Nurse practitioner" means a registered nurse certified by the Arizona State Board of Nursing to function as a nurse practitioner in the extended role under the provisions of A.R.S. Title 32, Chapter 15.
21. "Nursing unit" means an organized jurisdiction of nursing services such as a nurses' station and related service areas, special care unit, or outpatient clinic.
22. "Occupational therapist" means a person who is registered or is eligible for registration by the American Occupational Therapy Association, or who has completed the equivalent education requirements and work experience

necessary for such registration or who has completed the academic program and is in the process of accumulating the supervised work experience required to qualify for such registration.

23. "Outpatient surgical center" is a subclass of outpatient treatment center with facilities and limited hospital services for the diagnosis or treatment of patients by surgery whose recovery, in the concurring opinion of the surgeon and the anesthesiologist, will not require inpatient care.
24. "Outpatient treatment center" is a class of health care institution without inpatient beds which provides medical services for the diagnosis and treatment of persons on an outpatient basis.
25. "Outpatient treatment clinic" is a subclass of outpatient treatment center and is defined in A.R.S. § 36-421.01, as ". . . a facility or a portion of a facility where practitioners of the healing arts licensed under Title 32 may practice with necessary diagnostic and treatment facilities and where patients are not kept overnight as bed patients or treated under general anesthesia".
26. "Patient" means a person admitted to or receiving care in an institution.
27. "Personal care facility" means a subclass of nursing care institution which provides nursing and health-related services as specified in R9-10-913.
28. "Physician's assistant" means a person certified under the provisions of A.R.S. Title 32, Chapter 25.
29. "Qualified person" when used in connection with an occupation or position, means a person:
    a. Who is licensed or has certification, registration or other professional recognition, or if there are no such requirements or standards,
    b. Who has appropriate training, education, or relevant experience and demonstrates through job performance to the satisfaction of the chief administrative officer the ability to perform the required functions.
30. "Residential care institution" means a health care institution other than a hospital or a nursing care institution which provides resident beds and health-related services for persons who do not need inpatient nursing care. Residential care institutions shall not include:
    a. Facilities for the mentally retarded except that any other class of health care institution in such facility shall be appropriately licensed.
    b. Penal or correctional facilities maintained and operated by the state or a political subdivision thereof except that any other class of health care institution in such facility shall be appropriately licensed.
    c. Foster homes or child welfare agencies operated under a permit from the Department of Economic Security except that any other class of health care institution in such facility shall be appropriately licensed.
    d. A facility owned or rented as a personal residence in which health-related services may incidentally be provided among family members.
31. "Respiratory therapist" means a person registered or eligible for registration by the American Registry of Inhalation Therapist, Inc., and graduated from an American Medical Association approved respiratory care education and training program, or certified or eligible for certification by the Technician Certification Board of the American Association of Respiratory Therapy and practicing under the supervision of a registered or registration eligible respiratory therapist.
32. "Rural general hospital" means a subclass of hospital having 50 or less inpatient beds serving an area located not less than 20 surface travel miles distant from another general hospital or rural general hospital and which provides hospital services.
33. "Skilled nursing care facility" means a subclass of nursing care institutions which provides nursing and health-related services to patients as specified in R9-10-913.
34. "Special hospital" means a subclass of hospital which provides hospital services for persons having a specialized medical condition, and which limits admission, care and services to patients appropriate to the specialties for which it has qualified for licensure.
35. "Speech therapist" means a person who has been granted the certificate of clinical competence in speech pathology by the American Speech and Hearing Association, or who has completed the equivalent educational requirements and work experience required for such a certificate, or who has completed the academic program and is in the process of accumulating the supervised work experience required to qualify for such registration.
36. "Supervisory care services" means accommodation, board and general supervision, including assistance to persons in the self-administration of prescribed medications. For purposes of this definition, "general supervision" means protective oversight including daily awareness of resident functioning and continuous needs and functional level assessment, ability to intervene in a crisis situation and supervision in self-administration of medications.
37. "Treatment" is the medical, surgical or psychiatric management of a patient or procedure for the cure or amelioration of a disease or pathological condition.

Historical Note

Former Section R9-10-113 repealed, new Section R9-10-113 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-114. Classifications

A. Health care institutions are classified and subclassified as follows:
1. Hospitals
    a. General hospitals
    b. Special hospitals
    c. Rural general hospitals
2. Nursing care institutions
    a. Skilled nursing care facilities
    b. Intermediate care facilities
    c. Personal care facilities
3. Outpatient treatment centers
    a. Outpatient surgical centers
    b. Emergency treatment clinics
    c. Outpatient treatment clinics
    d. Health services clinics
4. Residential care institutions
    a. Supervisory care homes
5. Home health agencies
6. Infirmaries
7. Behavioral health service agencies.

B. Any facilities that are clearly health care institutions but do not come within any of the subclasses listed in Subsection (A) shall at a minimum meet the requirements of R9-10-115.

C. All health care institutions are subject to the provisions of Chapter 9 and 11 of this Title, except as otherwise specified, and all health care institutions are subject to all of the provisions of this Article and such other Articles in Chapter 10 that

may specifically relate to the subclass of institutions concerned.

Historical Note
Former Section R9-10-114 repealed, new Section R9-10-114 adopted effective February 4, 1981 (Supp. 81-1). Amended by adding paragraph (7) as an emergency effective November 17, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Amended by adding paragraph (7) as a permanent amendment effective August 2, 1984 (Supp. 84-4).

R9-10-115. Unclassified health care institutions

Implementation of the provisions of R9-10-114(B) shall be at the sole discretion of the Director or the Director's representative. Health care institutions not otherwise classified or subclassified in R9-10-114(A) shall include but need not be limited to the following:

1. Be adequately equipped and staffed by qualified personnel to meet the needs and assure the safety of persons attending the facility and conform to all applicable statutory requirements for the provision of health care.
2. Establish and maintain a record of each inpatient and outpatient documenting the assessment of the patient's health needs and all health care service the patient receives.
3. Maintain all parts of the facility, including its premises and equipment, neat, clean, free of insects, rodents, litter and rubbish. Policies and procedures shall be established and implemented for cleaning, sanitizing or sterilizing equipment and supplies.
4. Cause the facility's physical plant and equipment to be periodically inspected and, where appropriate, tested, calibrated, serviced or repaired to assure that they are functioning properly and reliably. Records shall be maintained to assure that appropriate inspections and maintenance of equipment is periodically accomplished by an appropriately qualified person.
5. Comply with applicable regulations adopted pursuant to A.R.S. § 36-136(G) for the control of communicable disease and maintenance of proper sanitation.
6. Comply with applicable fire and building codes.
7. Adopt policies and procedures that delineate the scope of services offered, hours of operation, admission and discharge criteria and type of staff provided.
8. Obtain certificates of need and/or permits, if applicable.

Historical Note
Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-116. Documentation

Where this Chapter requires an institution to have by-laws, rules, regulations, policies, procedures, plans, job descriptions, orders, reports, minutes of meetings, records, contracts, agreements, duty schedules, or any similar items, such requirement means written documents which shall be readily available for inspection by the Director or his representative.

Historical Note
Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-117. Transfer to another subclass

A licensed health care institution which seeks to change its license to a class or subclass outside the class in which it is licensed shall comply with all applicable construction standards adopted by reference in R9-1-412. If the change in license is to another subclass of the same licensed class, the requirements of the code adopted by reference in R9-1-412(A) are not applicable except for new construction or when remodeling is contemplated.

Historical Note
Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-118. Reserved

R9-10-119. Reserved

R9-10-120. Reserved

R9-10-121. General requirements for licensure

A. Application for licensure as a health care institution shall be made on an application form provided by the Department. If more than 1 subclass of license is desired for a single structure, separate applications shall be made and the areas to be covered by each license shall be clearly described.

B. Separate licenses are required for facilities maintained on noncontiguous premises except for branch offices of home health agencies and mobile and temporary clinics operated by governmental agencies. Structures for patient care activities on contiguous grounds and under the same ownership may be licensed as a single institution provided that they are not intersected by a public thoroughfare or, if so intersected, are connected by an all-weather enclosure. For the purpose of this regulation, the term "same ownership" may include either fee or leasehold ownership or a combination thereof.

C. Applications for licensure of leased premises shall contain a copy of the entire lease showing clearly the respective responsibilities of its parties for the maintenance and upkeep of the property and that the applicant has exclusive rights of possession subject only to normal and reasonable right of entry by the landlord.

D. Each licensed facility shall be designated by a distinctive name which shall not be changed without written notification to the Department. Upon receiving such notification, the license will be amended.

E. Persons acquiring a health care institution must obtain a new license at or immediately prior to transfer of ownership of the institution.

F. Applications shall be signed, in the case of an individual, by the owner of the health care institution, or in the case of a partnership, or a corporation, by two of the officers thereof, or in the case of a governmental unit, by the head of the governmental department having jurisdiction thereof. The signature(s) shall be notarized.

G. The governing body shall maintain in the administrative offices of the facility a current list of names and addresses of all persons or entities having 10% or more of the ownership interest as well as copies of all deeds, leases, land sale contracts or other documents evidencing control or ownership of the real property.

Historical Note
Amended effective February 4, 1981 (Supp. 81-1).

R9-10-122. Reserved

R9-10-123. Initial application

A. An initial application shall include supplementary information with the application form and is required whenever 1 of the following pertains:
1. Institutions seeking an original license in a subclass of health care institution or being relicensed following the revocation or suspension of license, or which have been temporarily closed.
2. Institutions which will have a change of ownership beginning with the new license.

B. In addition to the requirements of A.R.S. §§ 36-422 and 36-436, an initial application shall contain the following information:

1. Completed questionnaires on ownership, physical plant, staff, records and special services.
2. Fire and sanitation inspection reports unless otherwise specified in the Article applicable to its licensure.
3. Additional attachments required for approval of a clinical laboratory operated in conjunction with a health care institution, when applicable.

Historical Note

Amended effective February 4, 1981 (Supp. 81-1).

R9-10-124. Renewal application

A. The Department will notify the institution of the need to renew a license approximately 100 days prior to the expiration date of the then current license. Renewal applications shall be submitted on forms furnished by the Department.

B. In addition to the requirements of A.R.S. §§ 36-422 and 36-436, a renewal application shall contain the following information:
1. Completed questionnaires on ownership and staffing.
2. Fire and sanitation inspection reports unless otherwise specified in the Article applicable to its licensure.
3. Additional attachments required of institutions operating a clinical laboratory in conjunction therewith.

Historical Note

Former Section R9-10-124 repealed, new Section R9-10-124 adopted effective February 4, 1981 (Supp. 81-1).

ARTICLE 2. GENERAL HOSPITALS

R9-10-201. Reserved

R9-10-202. Reserved

R9-10-203. Reserved

R9-10-204. Reserved

R9-10-205. Reserved

R9-10-206. Reserved

R9-10-207. Reserved

R9-10-208. Reserved

R9-10-209. Reserved

R9-10-210. Reserved

R9-10-211. General

A. General hospitals to which these requirements apply shall be subject to inspection by personnel of the Department as provided in A.R.S. §§ 36-406 and 36-424. Department personnel are prohibited by A.R.S. § 36-404 from disclosing patient records or any information from which a patient or his family might be identified, or sources of information which cause the Department to believe that an inspection is needed to determine whether an institution is in compliance with the provisions of this Chapter and the regulations thereunder.

B. When a service has been contracted for, the hospital administration shall assure that the supplier is meeting the same standards of quality the hospital would have to meet if services were provided by the hospital.

C. Regulations contained in this Article shall not be construed to compel any patient to submit to any examination or treatment, however, all requirements for the control of communicable disease and sanitation must be met.

Historical Note

Former Section R9-10-211 renumbered as R9-10-311 as an emergency effective February 22, 1979, new Section R9-10-211 adopted effective February 23, 1979 (Supp. 79-1).

R9-10-212. Definitions

Unless the context otherwise requires:
1. "Ancillary nursing personnel" means persons employed to assist registered nurses or licensed practical nurses in the care of patients.
2. "Anesthesiologist" means a physician whose specialized training and experience qualify him to administer anesthetic agents and to monitor patients under the influence of these agents.
3. "Anesthetist" means a physician or dentist qualified by experience to administer anesthetic agents or a registered nurse who meets the requirements of A.R.S. § 32-1661.
4. "Audiologist" means a person who has been granted a Certificate of Clinical Competence in audiology by the American Speech and Hearing Association, or who has completed the equivalent educational requirements and work experience necessary for such a certificate, or who has completed the academic program and is in the process of accumulating the supervised work experience required to qualify for such a certificate.
5. "Audiology services" means those diagnostic, screening, preventive or other services provided by or under the supervision of an audiologist within the scope of practice of his profession.
6. "Chief executive officer" means a qualified person appointed by the governing authority to act in its behalf in the overall management of the hospital.
7. "Dentist" means a person so licensed under the provisions of A.R.S. Title 32, Chapter 11.
8. "Dietitian" means a person who meets the standards and qualifications established by the Commission on Dietetic Registration under the requirements in effect March 9, 1976.
9. "Department" means Department of Health Services.
10. "Direct nursing care" means the provision of preventative, curative, rehabilitative and health-related services directly to patients on a nursing unit by nursing personnel under the supervision of a registered nurse.
11. "Direction" means authoritative policy or procedural guidance for the accomplishment of a function or activity.
12. "Director" means the Director of the Department of Health Services.
13. "Director of nursing" means a registered nurse with supervisory and administrative ability who is responsible to the chief executive officer for supervision of nursing service for the entire facility for all shifts.
14. "Food service director" means a person who is a dietitian or a graduate of a dietetic technician, dietetic assistant or food service supervisor training program, correspondence school or classroom, approved by the American Dietetic Association; or who has training and experience in food service supervision and management equivalent to 1 of these programs.
15. "General hospital" means a subclass of hospital which provides inpatient beds and other hospital services, both surgical and non-surgical, to patients who have any of a variety of medical conditions.
16. "Governing authority" means the individual, agency or group or corporation appointed, elected or otherwise designated in which the ultimate authority and responsibility for the conduct of the hospital is vested.
17. "Hospital" means a class of health care institution which provides, through an organized medical or professional staff, services that include, but are not limited to, inpa-

tient beds, medical services and continuous nursing services for the diagnosis and treatment of patients.

18. "Infirmary" is a subclass of hospital having less than 50 inpatient beds providing limited hospital services to a distinct population such as an entire isolated community, the staff and students of a school, the members of an association or wards of a public agency.
19. "Licensed bed" means an individual patient care unit including a bed, nurse call system and related furniture, equipment and space as specified in these regulations.
20. "Licensed bed capacity" means the number of adult and pediatric beds specified on the hospital's license, and does not include bassinets, labor or recovery beds.
21. "Licensed nursing personnel" means registered and licensed practical nurses.
22. "Licensed practical nurse" means a person so licensed under the provisions of A.R.S. Title 32, Chapter 15.
23. "Medical staff" means physicians, dentists and other practitioners of the healing arts who are privileged by agreement with the hospital as defined in the hospital's medical staff by-laws to attend patients.
24. "New construction" means new buildings, addition to existing buildings, conversion of existing buildings or portions thereof or portions of buildings undergoing modification other than repair.
25. "Nurse practitioner" means a registered nurse certified by the Arizona State Board of Nursing to function as a nurse practitioner in the extended role under the provisions of A.R.S. Title 32, Chapter 15.
26. "Nursing unit" means an organized jurisdiction of nursing services such as nurses' station, special care unit, or outpatient clinic providing services to patients.
27. "Occupational therapist" means a person who is registered by or meets the requirements for registration by the American Occupational Therapy Association.
28. "Occupational therapy services" means those services provided by or under the supervision of an occupational therapist within the scope of the practice of his profession.
29. "Outpatient surgical center" is a subclass of outpatient treatment center with facilities and limited hospital services for the diagnosis or treatment of patients by surgery whose recovery, in the concurring opinion of the surgeon and the anesthesiologist, will not require inpatient care.
30. "Patients room" is a room designated and designed for 1 or more licensed beds, meeting the requirements of these regulations.
31. "Patient" means a person admitted to or receiving treatment in the hospital.
32. "Pharmacist" means a person registered under the provisions of A.R.S. Title 32, Chapter 18.
33. "Physical therapist" means a person registered under the provisions of A.R.S. Title 32, Chapter 19.
34. "Physical therapy services" means those services provided by or under the supervision of a physical therapist within the scope of the practice of his profession as defined by A.R.S. Title 32, Chapter 19.
35. "Physician" means a person licensed under the provision of A.R.S. Title 32, Chapter 13 or 17.
36. "Physician's assistant" means a person certified under the provisions of A.R.S. Title 32, Chapter 25.
37. "Private duty nurse" is a registered nurse or licensed practical nurse in the employ of the patient or his representative.
38. "Qualified person" when used in connection with an occupation or position, means a person:
    a. Who is licensed or has certification, registration or other professional recognition, or, if there are no such requirements or standards,
    b. Who has appropriate training, education, or relevant experience and demonstrates through job performance to the satisfaction of the chief executive officer the ability to perform the required functions.
39. "Registered nurse" means a person so licensed under the provisions of A.R.S. Title 32, Chapter 15.
40. "Social worker" means a person who has received a baccalaureate degree and has met the requirements of a two year curriculum in a school of social work that is accredited by the Council on Social Work Education, or has the equivalent of such education and training.
41. "Special care unit" means a designated area in which there are concentrated qualified and specially trained nursing and ancillary nursing personnel together with the necessary diagnostic, monitoring and special therapeutic equipment needed to provide optimal medical care for critically ill patients.
42. "Special hospital" is a subclass of hospital which provides hospital services for persons having a specialized medical condition; and which limits admission, care and services to those patients appropriate to the specialties for which it has qualified for licensure.
43. "Speech therapist" means a person who has been granted the Certificate of Clinical Competence in speech therapy by the American Speech and Hearing Association, or who has completed the equivalent educational requirements and work experience required for such a certificate, or who has completed the academic program and is in the process of accumulating the supervised work experience required for such a certificate.
44. "Speech therapy services" means those diagnostic, screening, preventive or other corrective services provided by or under the supervision of a speech therapist within the scope of the practice of his profession.
45. "Supervision" means direct overseeing and inspection of the act of accomplishing a function or activity.
46. "Therapist" means a person who is appropriately qualified by training, experience, or both, to apply diagnostic or treatment techniques and procedures for patients under the direction of a physician. Such persons who are required to have an Arizona license to practice their profession shall have the appropriate license.
47. "Treatment" is the medical, surgical or psychiatric management of a patient or procedure for the cure or amelioration of a disease or pathological condition.

Historical Note

Former Section R9-10-212 renumbered as R9-10-312 as an emergency effective February 22, 1979, new Section R9-10-212 adopted effective February 23, 1979 (Supp. 79-1).

R9-10-213. Administration

A. Governing authority: The governing authority shall adopt bylaws which identify the purposes of the hospital and the methods of fulfilling them. The governing authority shall appoint a chief executive officer who shall be appropriately qualified for the management of the facility. The chief executive officer shall have authority and responsibility for the operation of the hospital.

B. The chief executive officer shall be directly responsible to the governing authority for the management and operation of the hospital and shall provide liaison between the governing authority and the medical staff.

1. The chief executive officer shall maintain written definitions of the hospital organization, authority, responsibility and relationships, to provide the hospital with administrative direction.
2. When there is a planned change of the chief executive officer or ownership, the governing authority of the hospital shall notify the Department at least 30 days prior to the effective date of change. Such changes that cannot be planned in advance shall be reported in writing to the Department immediately.
3. The admitting office shall have written admission and discharge policies which are consistent with the established purposes of the hospital.
4. There shall be available at all times an employee authorized to accept patients for admission and to make administrative decisions concerning their disposition.
5. Inpatients shall be provided, at the time of their admission, a suitable device or method for identification.
6. Records and reports: The following documents, or copies shall be available in the hospital:
   a. Bylaws of the governing body,
   b. Bylaws and rules and regulations of the medical staff,
   c. Policies and procedures for all established hospital services,
   d. Reports of all inspections and reviews related to licensure for the preceding five years together with corrective actions taken,
   e. Contracts and agreements related to licensure to which the hospital is bound,
   f. Appropriate documents evidencing control and ownership,
   g. A current copy of Title 9 Health Care Regulations available from the Office of the Secretary of State:

Chapter 1, Article 4,	Codes and Standards referenced
Chapter 8, Article 1,	Food and Drink
Chapter 9, Articles 1,2,3,	Health Care Institutions: Establishment and Modification
Chapter 10, Article 1,	Health Care Institutions: Licensure
Chapter 11, Articles 1,2,3	Health Care Institutions: Rates and Charges

7. The Department recognizes that emergency situations do occur in which a general hospital may temporarily need to exceed its licensed capacity. The medical need to admit patients in excess of licensed bed capacity as indicated by service category as shown on the then current license shall be determined by a committee or other organizational structure of the medical staff. During any period in which the hospital's census exceeds its licensed bed capacity by category of service, it shall suspend all elective admissions to that service until its census is reduced to less than licensed bed capacity of that service category. The exception afforded by this Paragraph does not exempt a hospital from any other requirement of this Chapter.
8. Personnel
   a. Personnel records:
      i. A record of each employee shall be maintained which includes the following:
         (1) Employee's identification, including name, address and next of kin,
         (2) Resume of education and work experience,
         (3) Verification of valid license if required, education and training.
      ii. Payroll and attendance records for the preceding 12 month period shall be available for review by Department personnel.
      iii. Every position shall have a written description which describes the duties of the position.
   b. Orientation: New employees shall receive orientation to familiarize them with the facility, its policies, and the responsibilities of the new employee.
   c. In-service training: An in-service training program shall be conducted on a continuing basis for all nursing and dietary personnel. Records shall be maintained that include at least subject matter, attendance and date of training.
   d. An employee whose duties during his normal work shift require him to be awake while on the job, shall not be scheduled to work consecutive shifts.
   e. Health examinations: Prior to employment each employee shall have a general physical examination. An appropriate tuberculosis screening test shall be performed prior to employment and annually or as otherwise appropriate.
9. Miscellaneous
   a. Pets: There shall be no pets allowed in the patient care and food service areas of the hospital. For the purpose of these regulations, seeing eye dogs are not considered pets.
   b. Telephones: Unless bedside telephones are provided, patients shall have access to a public telephone.
   c. Keys: The person on duty and in charge of the hospital shall have reasonable access to all areas related to patient care and operation of the physical plant.
   d. Privacy: Reasonable privacy shall be provided for all patients.

Historical Note

Former Section R9-10-213 renumbered as R9-10-313 as an emergency effective February 23, 1979, new Section R9-10-213 adopted effective February 23, 1979 (Supp. 79-1).

R9-10-214. Medical staff

A. The hospital shall have an organized medical staff responsible to the governing authority for the quality of medical care provided to patients and for the ethical and professional practices of its members.

B. Patients shall be admitted to the hospital by a member of the medical staff in accordance with medical staff bylaws, and shall be under the general care of a physician.

C. The medical staff of a general hospital shall consist of two or more physicians.

D. The medical staff, subject to final action by the governing authority, shall adopt bylaws, rules and policies for the proper conduct of its activities. The medical staff shall recommend to the governing authority, physicians and other licensed practitioners considered eligible for new and continued membership on the medical staff, as delineated in medical staff bylaws. Clinical privileges of each medical staff member shall be delineated in writing.

E. The bylaws shall state the type, purpose, composition and organization of standing committees.

F. The medical staff shall be responsible to assure the availability of inpatient and outpatient physician services in the event of an emergency.

Historical Note
Former Section R9-10-214 renumbered as R9-10-314 as an emergency effective February 22, 1979, new Section R9-10-214 adopted effective February 23, 1979 (Supp. 79-1).

R9-10-215. Nursing services

A. Organization.
1. The hospital shall have an organized nursing service to provide nursing care to meet the needs of each patient.
2. There shall be a director of nursing.
3. Administrative and patient care policies and procedure for all nursing services provided shall be developed, periodically reviewed, and revised as necessary.

B. Staffing.
1. The nursing department shall be adequately staffed at all times based upon the number of patients and their acuity.
   a. A registered nurse shall be in charge of the nursing service at all times.
   b. There shall be at least two registered nurses on duty at all times when there are inpatients.
   c. Each nursing unit shall be staffed by at least 1 registered nurse; nursing units with more than 40 patients shall have an additional registered nurse.
2. A general staffing plan shall be maintained which shall include individual staffing patterns for each nursing unit, surgical and obstetrical suites, outpatient department, emergency services, and special care units.

C. Nursing care plans. There shall be a written nursing care plan developed for each patient consistent with the medical plan of care and coordinated with the total health team. The plan shall include the problems, needs, approaches and goals, and shall be available to all members of the health team.

D. Physician's orders. Telephone orders to nursing units shall be taken only by registered nurses or licensed practical nurses. If such orders are taken by a licensed practical nurse, they shall be reviewed and countersigned by a registered nurse prior to implementation.

Historical Note
Former Section R9-10-215 renumbered as R9-10-315 as an emergency effective February 22, 1979, new Section R9-10-215 adopted effective February 23, 1979 (Supp. 79-1). Amended subsection (D) effective August 31, 1988 (Supp. 88-3).

R9-10-216. Surgical services

A. The general hospital shall have at least 1 operating room.

B. A roster specifying the surgical privileges of physicians shall be kept in the operating room or suite.

C. The medical staff shall establish policies specifying the surgical procedures which will require a second physician as assistant in surgery.

D. A chronological register of surgical operations performed shall be maintained in the surgical suite.

E. Except in a documented emergency, a history shall be taken and physical examination shall be performed on every patient prior to surgery. Results shall be documented in the clinical record.

F. There shall be policies and procedures for the immediate postoperative care.

G. The operating room shall be supervised by a qualified registered nurse.

H. There shall be a registered nurse functioning as circulating nurse during each surgical procedure.

I. The operating room(s) and support services shall be located to prevent through traffic.

J. General anesthesia shall be administered by an anesthesiologist or an anesthetist, or by a trainee under the supervision of an anesthesiologist.

K. The recovery room shall be supervised by a qualified registered nurse.

L. There shall be available a current listing of all types of surgical procedures offered by the hospital. The current edition of the American Medical Association Procedural Terminology shall be used as a guide when preparing this list.

M. Policies shall be adopted regarding the content of, and timing for, anesthetic follow-up notes.

Historical Note
Adopted as an emergency effective April 2, 1976 (Supp. 76-2). Adopted effective August 25, 1977 (Supp. 77-4). Former Section R9-10-216 renumbered as R9-10-316 as an emergency effective February 22, 1979, new Section R9-10-216 adopted effective February 23, 1979 (Supp. 79-1).

R9-10-217. Dietetic services

A. Organization
1. The hospital shall have an organized dietetic department under the direction of a qualified food services director who has authority and accountability for the dietetic services.
2. Each hospital shall have at least 1 dietitian employed on either a full-time, part-time or consultant basis to direct the nutritional aspects of patient care and to advise on food preparation and services.
3. There shall be written policies and procedures established for all dietetic services.

B. Staffing
1. Staffing of dietetic services shall be maintained at levels to assure adequate production and delivery of food.
2. Time schedules and job assignments shall be on file.
3. Adequate numbers of dietitians, technical, clerical and other appropriately qualified personnel shall be employed to complete all dietary functions.

C. Facilities. Adequate space, equipment, and supplies shall be provided for the efficient, safe and sanitary receiving, storage, refrigeration, preparation and service of food.

D. Nutritional care
1. A current diet manual shall be readily available to attending physicians, food service personnel, and licensed nursing personnel.
2. Pertinent observations and information related to special diets, patient's food habits and dietetic treatment shall be recorded in the patient's medical record.
3. A written order for modified diet prescriptions as recorded in the patient's medical record shall be kept on file in the dietetic services office throughout the duration of the order.

E. Sanitation. Food service sanitation shall be maintained in accordance with the Department's Regulations Chapter 8, Article 1, Food and Drink.

Historical Note
Adopted effective February 23, 1979 (Supp. 79-1).

R9-10-218. Emergency services

A. A general hospital is not required to staff or equip a full time emergency department, but necessary emergency medical services shall be provided in a designated area of the hospital.

The hospital shall have procedures whereby the ill or injured person will be assessed and treated or referred to an appropriate facility.

B. Emergency services shall be provided to any person in need of them. If the hospital offers only a partial range of services and elects to transfer the patient for further care, essential lifesaving measures and emergency procedures shall be instituted that will minimize aggravation of the condition during transportation. A patient shall be transferred only to a receiving institution that has consented to accept that patient. A record of the immediate medical problem and treatment provided shall accompany the patient.

C. There shall be written policies approved by the medical staff and adopted by the governing authority establishing the extent of treatment to be carried out by the emergency service. These written policies shall provide for transfer to facilities offering specialized care.

D. There shall be a physician responsible for the overall medical direction of emergency services.

E. The emergency services of a general hospital shall maintain the following minimum staffing requirements:

1. A current roster of physicians on call.
2. A registered nurse immediately available within the hospital.
3. A laboratory technician on call.
4. A radiologic technician on call.

Historical Note

Adopted effective February 23, 1979 (Supp. 79-1).

R9-10-219. Disaster preparedness

A. Disaster plan: There shall be a written plan of operation with procedures to be followed in the event of a disaster. The plan shall be developed in two phases:

1. Phase one -- Internal disasters such as fire, gas explosion, etc. Policies and procedures shall include:
   a. Notification of personnel and assignment of responsibilities.
   b. Instructions regarding the location and use of fire alarm systems and fire fighting equipment.
   c. Provision for each type of internal disaster (fire, bomb scare, etc.).
   d. Provisions for evacuation, including priorities for evacuation and disposition.
   e. Management of casualties.
   f. Emergency feeding plan.
2. Phase two -- External disasters such as mine explosion, bus accidents, flood, earthquakes, etc. Policies and procedures shall include:
   a. Notification of personnel and assignment of responsibilities.
   b. Communications with other facilities.
   c. Unified medical command.
   d. Establishment of a triage unit and its location.
   e. Transfer of patients.
   f. Method of identifying patients.
   g. Establishment of an emergency treatment record.
   h. Public information center.
   i. Security.
   j. Method to obtain necessities (water, food, etc.).
   k. Determination of availability of beds, blood, medical supplies, etc.
   l. Emergency feeding plan.

B. Disaster and fire drills: At least 12 fire drills shall be held each year. They shall be conducted at irregular intervals and at least four times on each shift. At least 1 disaster drill shall be held on each shift each year. Fire and disaster drills may be combined and may accommodate more than 1 shift.

Historical Note

Adopted effective February 23, 1979 (Supp. 79-1).

R9-10-220. Environmental services

A. A committee composed of members of the medical staff, nursing staff, laboratory staff, and other appropriate persons shall develop policies and procedures for investigating, controlling and preventing infections in the hospital and shall monitor staff performance in implementation of these procedures. All cases of reportable diseases shall be reported in accordance with applicable rules and regulations adopted by the Department. There shall be a method of control used in relation to sterilization of supplies and water and a written policy requiring sterile supplies to be reprocessed at specified time periods.

B. The hospital shall be kept clean, free of insects, rodents, litter and rubbish. All areas shall be regularly and appropriately cleaned in accordance with administrative policies and procedures.

C. The hospital physical plant, including equipment, shall be periodically inspected and, where appropriate, tested, calibrated, serviced or repaired to assure that all equipment is free of fire and electrical hazards and is functioning properly. Records shall be maintained to assure that appropriate inspections and maintenance of equipment are periodically accomplished by qualified personnel.

D. There shall be available at all times clean linen essential to the proper care and comfort of the patients. Linens shall be handled, stored, processed and transported in a manner which will prevent the spread of infection.

E. All potentially hazardous wastes such as waste from isolation rooms and materials contaminated with secretions, excretions or blood, patient care and laboratory animal care wastes, laboratory wastes and the like shall be sterilized by autoclaving and buried in a Department approved sanitary landfill or may be disposed of by incinerating in an incinerator approved by the Air Pollution Control Officer having jurisdiction. Provisions of A.C.R.R. Title 9, Chapter 8, Article 4 pertaining to disposal of such material shall be observed.

F. When oxygen is being used, the following precautions shall be taken:

1. A warning sign shall be placed at each entrance to the room.
2. Ash trays, matches, and other smoking material shall be removed from the room.
3. Oxygen tanks shall be secured at all times. Additional precautions shall be taken in accordance with the Life Safety Code adopted by reference in R9-1-412(B) and the Inhalation Anesthetics Code adopted by reference in R9-1-417(A).
4. Hydrocarbon greases shall not be used.

G. Electrical safety

1. Extension cords shall not be used except for maintenance services.
2. Equipment and appliances, including radios and television sets, which use electricity as a source of energy shall be grounded.
3. Additional precautions shall be taken in accordance with the National Electrical Code adopted by reference in R9-1-412(E).

H. There shall be written policies concerning syringe and needle storage, handling and disposal.

I. Water supply shall be in accordance with the Department's regulations contained in A.C.R.R. Title 9, Chapter 8, Article 2.

Historical Note
Adopted effective February 23, 1979 (Supp. 79-1).

R9-10-221. Medical records services

A. There shall be a medical records department under the direction of a qualified person and with adequate staff and facilities to perform all required functions.

B. A medical record shall be established and maintained for every person receiving treatment as an inpatient, outpatient, or on an emergency basis in any unit of the hospital. The records shall be available to other units engaged in care and treatment of the patient.

C. Only authorized personnel shall have access to the records.

D. Medical record information shall be released only with the written consent of the patient, the legal guardian, or in accordance with law.

E. In hospitals that have designated psychiatric or substance abuse units confidentiality of medical records shall be maintained as required by A.R.S. § 36-509 and applicable Regulations.

F. For licensing purposes medical records shall be readily retrievable for a period of not less than three years, except that A.R.S. § 36-343 requires retention of vital records and statistics for ten years.

G. The original or signed copy of all clinical reports shall be filed in the medical record.

H. Medical records shall be indexed to facilitate continuity of care, acquisition of statistical medical information and retrieval of records for research or administrative action.

I. Within 48 hours of admission a current or updated history and physical examination shall be in the record.

J. When a patient is readmitted within thirty days for the same problem, there shall be at least a reference to the previous history by an interval note.

K. Histories and physicals shall be written by members of the medical or the house staff. When authorized by medical staff bylaws, physicians assistants and nurse practitioners may write or dictate medical histories and results of physical examinations; such entries shall be counter-signed by the attending physician. A physician's signature shall be required on each page of the record which bears his notation or a notation made by a physician assistant or nurse practitioner under his direction.

L. The person responsible for each entry shall be identified by initials or signature. If initials are used the person's signature must appear on the page.

M. Medical records of discharged patients shall be completed within the time limit established by the medical staff.

N. Inpatient medical records shall contain the following information if applicable:
1. Patients identification sheet, including name, address, date of birth, sex, next of kin and a unique identifying number,
2. History and physical examination,
3. Physicians' orders, and progress notes,
4. Laboratory and diagnostic reports,
5. Nursing notes,
6. Nursing care plans,
7. Medication and treatment record,
8. Admitting diagnosis,
9. Disposition and discharge diagnosis,
10. Record of informed consent,
11. Discharge summary.

O. The outpatient's medical record shall be accessible.
1. In outpatient departments that are organized by clinics, the following information shall be available:
   a. Patient's identification sheet,
   b. History and physical examination,
   c. Physician's orders,
   d. Any laboratory and other diagnostic tests, diagnosis and treatment,
   e. Disposition.
2. If outpatient services are provided in other than an organized outpatient clinic, the following information shall be available:
   a. Patient's identification,
   b. That information pertaining to the patient's chief complaint including, but not limited to, physician's orders, treatment or service provided, and disposition.

P. The emergency services record shall contain the following:
1. Patient identification,
2. Record of any treatment patient received prior to arrival,
3. History of disease or injury,
4. Physical findings,
5. Laboratory and x-ray reports, if applicable,
6. Diagnosis,
7. Record of treatment,
8. Disposition,
9. Name of physician who saw patient in the emergency room.

Q. All deaths, abortional acts, post-mortem procedures and births shall be reported in accordance with A.C.R.R. Title 9, Chapter 19.

R. If a facility ceases operation, there shall be an arrangement for preservation of records to ensure compliance with these regulations. The Department shall be notified, in writing, concerning the arrangements.

S. Symbols or abbreviations used in the medical record shall be approved by the medical staff and a current copy maintained at each nursing unit and in the medical record department.

Historical Note
Former Section R9-10-221 renumbered as R9-10-317 as an emergency effective February 22, 1979, new Section R9-10-221 adopted effective February 23, 1979 (Supp. 79-1).

R9-10-222. Laboratory services

A. Minimum capability
1. There shall be within the hospital the capability of providing clinical laboratory services required to support emergency services.
2. There shall be arrangements for the provision of clinical and anatomical pathology services necessary to meet the needs of hospitalized patients.
3. Clinical laboratory services, may be provided by another hospital laboratory, an independent clinical laboratory or an out-of-state laboratory providing the following conditions are met:
   a. The contracting laboratory is licensed by the Department or, in the case of out of state clinical laboratories, is licensed by the United States Government, to perform the contracted laboratory services.
   b. The conditions, procedures and type of examinations performed by the contracting laboratory or hospital shall be in writing and available in the hospital.

B. Administration
1. Clinical laboratory services shall be under the direction of a physician with training and experience in clinical laboratory services, or a person who holds a doctoral degree from an accredited institution with a chemical, physical or biological science as his major subject and who is

qualified to perform at least 1 of the technical services provided by the laboratory. Anatomical pathology service shall be provided by a pathologist.

2. A qualified person shall be appointed to be in charge of the laboratory in the absence of the Director.
3. At least 1 qualified laboratory technician shall be on duty or on call at all times.

C. Examination of specimens, written requests, reports of results, retention of test records.

1. Except as otherwise provided, laboratory personnel shall examine specimens only at the request of a physician authorized to practice medicine and surgery or other persons permitted by law to use the findings of laboratory examinations or at the request of the Department for the purpose of quality control and proficiency testing.
2. Results of tests shall be reported to the physician and entered in the patient's chart. No clinical interpretation, diagnosis, prognosis or suggested treatment shall appear on the laboratory report form except that a report made by a physician may include such information.
3. All specimens received by the laboratory shall be tested on the premises, or may be forwarded for analysis to another laboratory licensed under A.R.S. Title 36, Chapter 4.1, Article 2, or licensed as part of a general hospital or exempted by A.R.S. § 36-461(4). Specimens submitted for proficiency testing shall be analyzed on the premises by regularly assigned personnel using the laboratory's routine methods.
4. When the laboratory performing the analysis is other than the laboratory which initially received the specimen, the report shall include the name, address and name of the director of the laboratory actually performing the analysis.

D. Quality control program

1. Each laboratory director shall establish and file with the Department a detailed description of the services to be provided by the laboratory and of a quality control program that is acceptable to the Department and meets the standard specified in R9-14-108. It is the responsibility of the laboratory director to assure that the laboratory is operated in accordance with its approved quality control program.
2. Each laboratory shall participate successfully in a proficiency testing program provided by the American Association of Bioanalysts or the College of American Pathologists for each authorized specialty and subspecialty. Records of such testing shall be kept for two years and shall be available for examination by representatives of the Department. Laboratory personnel shall enter the date and time of receipt of samples, results and other information as may be required on forms provided by the proficiency testing service.
3. Each laboratory shall participate successfully in a Department operated proficiency testing program if the laboratory seeks authorization in a specialty or subspecialty for which proficiency testing is not available under Subsection (D) Paragraph (2) or if the Department needs additional assurance of the laboratory's proficiency. Such testing may be carried out during on-site inspections or by submittal of specimens by mail. Regularly assigned personnel shall examine samples using the laboratory's routine methods. The laboratory will be tested only in specialties or subspecialties for which an authorization has been issued by the Department. Proficiency test samples shall be tested within the time required under conditions of normal laboratory operation. Laboratory personnel shall enter the date and time of receipt of samples, results and other information as may be required on forms provided by the Department.

E. Sanitation and safety requirements. All laboratories shall be maintained and operated in a manner which prevents undue physical, chemical and biological hazards to hospital patients, employees or other members of the community and in accordance with standards specified in R9-14-109.

F. Maintenance, availability, retention of records

1. Records of observations shall be made concurrently with the performance of each step in the examination of specimens. The actual results of all control procedures shall be recorded.
2. Records shall identify the individual performing the examination. Such records as well as duplicate copies of laboratory reports shall be retained in the laboratory area for a period of at least 1 year after the date the results are reported.
3. A.R.S. § 25-103.06 requires that copies of premarital serology results be retained for five years.

G. Blood services. Hospitals shall have facilities adequate for the procurement, storage and transfusion of blood and blood components. Records of the donor and recipient of all blood handled shall be available. All transfusion reactions occurring in the hospital shall be investigated by the medical staff and an incident report shall be prepared.

Historical Note

Former Section R9-10-222 renumbered as R9-10-318 as an emergency effective February 22, 1979, new Section R9-10-222 adopted effective February 23, 1979 (Supp. 79-1). Correction, subsection (D)(3) reference to paragraph (E)(2) should read Subsection (D)(2). (Supp. 79-6).

R9-10-223. Pharmaceutical services

A. The hospital shall maintain pharmaceutical services which comply with A.R.S. Title 36, Chapter 9 and A.R.S. Title 32, Chapter 18 and all applicable regulations adopted by the Board of Pharmacy pursuant thereto.

B. There shall be a pharmacy and therapeutics committee composed of members of the medical staff, pharmacists, and other appropriate personnel.

C. Administration of drugs

1. Procedures shall be established to assure that drugs are administered only by persons authorized by state statutes and regulations.
2. Procedures shall be established to ensure that drugs are checked against physician's orders, that the patient is identified prior to administration of the drug, that each patient has an individual medication record, and that the dose of a drug administered to that patient is properly recorded therein by the person who administers the drug.
3. Drugs and biologicals shall be administered as soon as possible by a physician or the person who prepares them for administration. Preparation for administration shall not be interpreted as dispensing.

Historical Note

Former Section R9-10-223 renumbered as R9-10-319 as an emergency effective February 22, 1979, new Section R9-10-223 adopted effective February 23, 1979 (Supp. 79-1).

R9-10-224. Rehabilitation services

A. For purposes of this Section rehabilitation services include physical therapy, occupational therapy, speech therapy and audiology services.

B. The following provisions shall be met in hospitals that provide rehabilitation services:
1. Rehabilitation services shall be provided by a qualified therapist only when ordered by a physician. Rehabilitation services may be provided by qualified aides and assistants only when under the direct supervision of qualified therapists.
2. There shall be written administrative and patient care policies and procedures for each of the rehabilitation services offered.
3. There shall be a written plan for each patient indicating the modality or type of treatment provided and the frequency of treatment. This plan shall be based on the written order of a physician.
4. There shall be written documentation in the patient's medical record of the rehabilitation services provided.

Historical Note
Adopted effective February 23, 1979 (Supp. 79-1).

R9-10-225. Quality assurance

A. Each hospital shall have a quality assurance program conducted in accordance with A.R.S. § 36-445. A record of such activities shall be maintained.
B. A discharge planning program shall be established to provide for the transfer of information between hospital and other health facilities or agencies to facilitate continuity of care. Periodic review and evaluation of the program shall be conducted by a committee established for this purpose.

Historical Note
Adopted effective February 23, 1979 (Supp. 79-1).

R9-10-226. Radiology services

A. A hospital shall have within the hospital as a minimum the capability of providing emergency diagnostic radiology services.
B. A physician shall be responsible for the medical direction of the Department.
C. A radiologic technician shall be on duty or on call at all times.
D. There shall be a radiologic procedure manual available to radiology services personnel.
E. X-ray examinations shall be performed only when ordered by a member of the medical staff. The order shall contain a concise statement of the reason for the examination.
F. The radiology department shall be staffed, equipped and operated in accordance with A.R.S. Title 30, Chapter 4 and regulations adopted thereunder.

Historical Note
Adopted effective February 23, 1979 (Supp. 79-1).

R9-10-227. Respiratory care services

Hospitals that provide respiratory care services shall meet the following provisions:
1. Respiratory care services shall include therapeutic procedures and may include diagnostic procedures.
2. A physician shall be responsible for the medical direction of the respiratory care unit or department.
3. Respiratory care services shall be provided in accordance with the written order of a physician. The order shall state the modality to be used, the type, frequency and duration of treatment and type and dose of medication including dilution ratio.
4. Reports of respiratory care services shall be made a part of the patient's medical record.
5. Respiratory therapy shall be administered by qualified personnel.

Historical Note
Adopted effective February 23, 1979 (Supp. 79-1).

R9-10-228. Special care units

If the hospital offers intensive care services or cardiac care services, the following provisions shall be met:
1. Administration
   a. A member of the medical staff, experienced in providing care to seriously ill patients, shall be responsible for direction of the special care services. He shall be a member of the appropriate special care committee.
   b. There shall be 1 or more multidisciplinary commit tees to review policies and procedures of special care services. These committees shall establish operational guidelines and nursing action plans for each special care unit.
2. Personnel requirements
   a. A registered nurse shall be in charge of each separate unit on each shift. This individual shall have completed an intensive care or cardiac care training course and shall have work experience in an intensive care or cardiac unit.
   b. There shall be 1 registered nurse for three or less patients in a special care unit. Nurses assigned to the unit shall have demonstrated proficiency in intensive or cardiac care and shall be competent in:
      i. The recognition, interpretation, and recording of signs and symptoms in the critically ill patients,
      ii. Arrhythmia interpretation,
      iii. The initiation of cardiopulmonary resuscitation,
      iv. The parenteral administration of electrolytes and fluids,
      v. The effective and safe use of equipment in the unit,
      vi. The performance of specialized nursing procedures peculiar to the needs of patients in the unit,
      vii. The prevention of contamination and cross-infection,
      viii. The exercise of appropriate safety precautions in the use of electrical and electronic equipment, and
      ix. The recognition of the need for psychological and social services for patients and their families.
   c. Private duty nurses shall not be permitted to function in intensive care or cardiac care units. For purposes of this Chapter nursing pool personnel employed temporarily as hospital staff are not considered private duty nurses.
3. Policies and procedures
   a. There shall be admission and discharge criteria.
   b. There shall be recommended diagnostic and treatment programs which include delineation of authority extended to the specially trained nursing staff to initiate individual emergency care pending the arrival of a physician.
4. Equipment
   a. Minimum monitoring equipment shall include:
      i. Bedside electrocardiograph monitoring screens,
      ii. Heart rate indicator with alarm at the nurses' station,

iii. Central monitor for display of each patient's electrocardiogram at the nurses' station,
iv. A direct writing electrocardiographic recorder as an integral part of the monitoring system. This requirement does not apply to an intensive care unit when this equipment is available in a separate cardiac care unit.

b. Resuscitative and other emergency equipment shall include:
i. One defibrillator in each unit and at least 1 additional defibrillator available within the hospital.
ii. A minimum of two transvenous pacemaker catheters in the unit for the first two beds, and 1 additional transvenous pacemaker for each additional five beds. One battery powered external demand pacemaker shall be available in the unit. At least 1 additional battery powered external demand pacemaker shall be available in the hospital.
iii. An emergency cart containing the drugs and emergency equipment required for the immediate care of emergencies. The emergency cart shall be inventoried on each shift, as well as after each use by a designated person, unless it is in a sealed unit and the seal is intact. Written documentation of this inventory shall be maintained.

5. The special care unit shall be located to eliminate through traffic.

Historical Note
Adopted effective February 23, 1979 (Supp. 79-1).

R9-10-229. Obstetrical services

In hospitals providing obstetrical services, the following shall apply:

1. There shall be a registered nurse in charge of the delivery room and on duty there whenever patients are in the unit.
2. There shall be policies and procedures adopted by the medical staff in accordance with the Standards for Obstetric-Gynecologic Hospital Services adopted by reference in R9-1-413(A) which provides for:
   a. Mixing of non-maternity patients with maternity patients.
   b. The use of operating rooms for delivery.
   c. Surgical procedures performed in the delivery room.
3. Designated delivery rooms shall be provided with necessary supplies and equipment.
4. Policies for the administration of oxytocic drugs, analgesics, and anesthetics shall be written.
5. Equipment and supplies for anesthesia shall be readily available.
6. Resuscitation equipment shall be available.
7. A warming device that is free from fire or electrical hazards and capable of minimizing neonatal heat loss shall be available.
8. Every newborn shall be identified by two reliable methods before removal from the delivery room other than in an emergency.
9. A chronological register of deliveries and surgical procedures shall be maintained in the delivery area.
10. Antepartum and postpartum care shall be under the supervision of a registered nurse.
11. Newborn nursery
    a. A registered nurse shall be in charge of the nursery at all times.
    b. A nursery shall be provided for the care of newborns and shall not be used for any other purpose.
    c. A room in which "rooming-in" is practiced shall not be considered a nursery unless more than two mothers are accommodated in which case all requirements for newborn nurseries shall apply.
    d. An individual bassinet shall be provided for each newborn and each newborn shall have separate equipment and supplies.
    e. The use of common bathing or dressing areas is prohibited. All bathing, diaper changing, and treatments shall be carried out in the bassinet or on the newborn's individual shelf or drawer.
    f. Accurate scales shall be provided.
    g. Any newborn born outside of the hospital and any newborn suspected of having an infection or who has been exposed to actual or potential infection shall be properly isolated. The decision to transfer a newborn from the main nursery to isolation may be made by the nurse in charge of the main nursery in an emergency.
    h. Only persons, specified by hospital rules and regulations, shall be admitted to any nursery.
    i. Containers shall be provided for soiled diapers to ensure proper disposal.
    j. Underwriters Laboratory-approved isolettes shall be available.
    k. The use of a rack or bassinet stand which holds more than 1 bassinet is prohibited.
    l. Oxygen, oxygen equipment and suction equipment adapted to the use of newborn infants shall be available. An oxygen analyzer shall be available.
    m. Formula shall be prepared in an appropriate isolated area.
    n. Traffic in the nursery shall be closely supervised by the registered nurse in charge.
    o. Sanitized nursery linens or disposable linens shall be used.
    p. Whenever two or more infants in a nursery exhibit symptoms of a communicable illness, the incident shall be reported to the Department as required by A.C.R.R. Title 9, Chapter 6.
12. Hospitals that do not provide obstetrical services but have only emergency obstetrical capabilities shall have:
    a. A designated area within the hospital where emergency obstetrical services may be performed.
    b. Necessary supplies and equipment to provide emergency obstetrical services.
    c. At least 1 Underwriter Laboratory-approved isolette.

Historical Note
Adopted effective February 23, 1979 (Supp. 79-1).

R9-10-230. Pediatric services

Hospitals with an organized pediatric department shall have distinct facilities for the care of children. There shall be facilities and procedures for the isolation of children with communicable diseases.

1. Policies shall be established to cover conditions under which parents may stay with their child.
2. The standards for the Care of Children in Hospitals adopted by reference in R9-1-413(C) are recommended as a guide for pediatric services in hospitals.

Historical Note
Adopted effective February 23, 1979 (Supp. 79-1).

R9-10-231. Social services

When a hospital has an organized social service department the following conditions shall be met:

1. There shall be policies and procedures relating to the staff and functions of the department.
2. Personnel
   a. The social service department shall be under the direction of a social worker and shall have adequate staff and facilities to perform all required functions; or
   b. Social services shall be provided by a designated person who shall receive consultation from a social worker in accordance with a written agreement; or
   c. Social services shall be provided by referral, based on established written procedures, to appropriate social agencies.
3. Social services to patients shall be initiated by physician referral, or by request of patient, family member or guardian.
4. Social services information shall be recorded. Policies and procedures shall be established by the department with approval of the medical staff which specify the type and extent of this information to be placed in the medical record.
5. Facilities shall be provided which are accessible to patients and staff and which assure privacy for interviews.

Historical Note

Former Section R9-10-231 renumbered as R9-10-320 as an emergency effective February 22, 1979, new Section R9-10-231 adopted effective February 23, 1979 (Supp. 79-1).

R9-10-232. Hospital physical plant

A. Physical plant -- existing facilities

1. The physical plant of all hospitals licensed prior to adoption of these regulations shall meet the requirements of the Sections applicable to existing hospitals in the Life Safety code adopted by reference in regulation R9-1-412(B).
2. Appropriate drawings shall be submitted to the Department for any additions, alterations, or modifications, to the physical plant before work is undertaken.
3. Alterations to the existing physical plant shall conform to new construction standards.

B. Physical plant -- new construction

1. All new construction shall meet the minimum requirements of the applicable provisions of all codes and standards adopted by reference in R9-1-412 in accordance with their scope and applicability as specified in regulation R9-1-411.
2. Unless otherwise specified in this Section, patient rooms in newly constructed hospitals shall conform to the following minimum and maximum sizes:

Type of Accommodations	Minimum (Sq. Ft.)	Minimum (Sq. M.)	Maximum* (Sq. Ft.)	Maximum* (Sq. M.)
Private	100	9.29	150	13.94
2 Bed	160	14.86	230	21.37
3 Bed	240	22.30	310	28.80
4 Bed	320	29.73	390	36.23

* Exception: Maximum areas may be exceeded if the number of beds is limited by the configuration of the room, and when approval has been obtained from the Department.

3. Capacity of patient rooms (excluding special care units) shall not exceed 4 beds.
4. All patient room doors required to be self-closing by the Uniform Building Code adopted by reference in R9-1-412(A) shall be equipped with hold-open device. The device, upon activation of the fire alarm system, automatic fire extinguishing system and related products of combustion detectors, shall allow the door to close automatically.

C. All new and existing hospitals shall meet the following physical plant and safety factors:

1. Multi-bed rooms shall be designed and arranged to permit no more than two beds side by side parallel to the window wall with at least three feet (91 cm) between beds and three feet (91 cm) between bed and wall except at the head of the bed.
2. All patient rooms other than in intensive care units shall be outside rooms. The window area in each patient room shall be at least 1/8 of the floor area. Suitable window shades or drapes shall be provided as a means of controlling light.
3. Each bed shall have a nurse call system which conforms to the standard adopted by reference in R9-1-412(F).
4. Each patient room shall be numbered. The Department shall be notified when room numbers are changed.
5. Hospitals licensed prior to the adoption of these regulations shall have a minimum ratio of 1 toilet, 1 lavatory and 1 tub or shower for each 10 beds on each floor.
6. All toilet rooms, bathrooms, utility rooms, and janitor's closets shall have mechanical ventilation providing a minimum number of air changes per hour as specified in the code adopted by reference in R9-1-412(F).
7. There shall be adequate storage spaces or alcoves to store wheelchairs, walkers, and similar equipment when not in use. No corridors or stairwells shall be used for storing such equipment.
8. There shall be adequate space for the preparation, cleaning, sterilization and storing of supplies and equipment.
9. There shall be at least 1 room for isolation of patients with a communicable disease for each 100 beds or fraction thereof. The isolation room shall contain a private toilet and lavatory facilities.
10. Separate adequate storage space for each patient shall be provided within the patient's room.
11. Newborn nurseries shall have at least twenty-four square feet (2.23 sq. M) of floor space for each bassinet with two feet (61 cm) between bassinets.
12. Pediatric nurseries shall have at least forty square feet (3.72 sq. M) of floor space for each bassinet.
13. Pediatric beds shall have the same space requirement as adult patient beds.

14. Items such as drinking fountains, telephone booths, vending machines, furniture, and medical equipment shall be located so that they do not reduce the required width of exit corridors.
15. No door which is required to be fire rated shall be held open except with a device approved by the codes adopted by reference in R9-1-412.
16. Patient beds licensed after June 19, 1964 shall maintain the following minimum square footage per bed.
    a. One bed rooms -- 100 square feet (9.29 sq. M) per bed.
    b. Multi-bed rooms -- 80 square feet (7.43 sq. M) per bed.
17. Multi-patient rooms licensed at 70 square feet (6.50 sq. M) per bed before and continuously since June 19, 1964 may retain the 70 square feet (6.50 sq. M) per bed.

Historical Note

Former Section R9-10-232 renumbered as R9-10-321 as an emergency effective February 22, 1979, new Section R9-10-232 adopted effective February 23, 1979 (Supp. 79-1).

R9-10-233. Rates and charges

The current schedule of rates and charges shall be posted in accordance with R9-11-114(H), and R9-10-1734.

Historical Note

Former Section R9-10-233 renumbered as R9-10-322 as an emergency effective February 22, 1979, new Section R9-10-233 adopted effective February 23, 1979 (Supp. 79-1).

ARTICLE 3. RURAL GENERAL HOSPITALS

R9-10-301. Reserved

R9-10-302. Reserved

R9-10-303. Reserved

R9-10-304. Reserved

R9-10-305. Reserved

R9-10-306. Reserved

R9-10-307. Reserved

R9-10-308. Reserved

R9-10-309. Reserved

R9-10-310. Repealed

Historical Note

Adopted as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 4, 1979 (Supp. 79-3). Amended effective January 28, 1980 (Supp. 80-1). Repealed effective February 4, 1981 (Supp. 81-1).

R9-10-311. General

A. Rural general hospitals to which these requirements apply are subject to inspection as provided in A.R.S. §§ 36-406 and 36-424. Department personnel are prohibited by A.R.S. § 36-404 from disclosing patient records or any information from which a patient or his family might be identified, or sources of information which cause the Department to believe that an inspection is needed to determine whether an institution is in compliance with the provisions of this Chapter and the regulations thereunder.

B. The rural general hospital administration shall assure that contract suppliers meet the same standards of quality the hospital would have to meet if services were provided by the hospital.

C. Regulations contained in this Article shall not be construed to compel any patient to submit to any examination or treatment provided all requirements for the control of communicable disease and sanitation are met.

D. It is not the intent of this regulation to require a general hospital having less than 50 inpatient beds to apply for licensure as a rural general hospital. It shall be the prerogative of the governing authority to determine the type of licensure for which it will apply.

Historical Note

Section R9-10-311, formerly numbered as R9-10-211, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-311 repealed, new Section R9-10-311 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-312. Definitions

Unless the context otherwise requires:

1. "Anesthesiologist" means a physician whose specialized training and experience qualify him to administer anesthetic agents and to monitor patients under the influence of these agents.
2. "Anesthetist" means a physician or dentist qualified by experience to administer anesthetic agents or a registered nurse who meets the requirements of A.R.S. § 32-1661.
3. "Chief executive officer" means a qualified person appointed by the governing authority to act in its behalf in the overall management of the hospital.
4. "Direct nursing care" means the provision of preventative, curative, rehabilitative and health-related services directly to patients on a nursing unit by nursing personnel under the supervision of a registered nurse.
5. "Food service director" means a person who is a dietitian or a graduate of a dietetic technician, dietetic assistant or food service supervisor training program, correspondence school or classroom, approved by the American Dietetic Association, or who has training and experience in food service supervision and management equivalent to 1 of these programs.
6. "General hospital" means a subclass of hospital which provides inpatient beds and other hospital services, both surgical and non-surgical, to patients who have any of a variety of medical conditions.
7. "Hospital" means a class of health care institution which provides, through an organized medical or professional staff, services that include, but are not limited to, inpatient beds, medical services and continuous nursing services for the diagnosis and treatment of patients.
8. "Licensed bed capacity" means the number of adult and pediatric beds specified on the rural general hospital's license, and does not include bassinets, labor or recovery beds.
9. "Rural general hospital" means a subclass of hospital having 50 or less inpatient beds serving an area located not less than 20 surface miles from another general or rural general hospital and which provides hospital services.
10. "Social worker" means a person who has received a baccalaureate degree and has met the requirements of a two-year curriculum in a school of social work that is accred-

ited by the Council on Social Work Education, or has the equivalent of such education and training.

11. "Therapist" means a person who is appropriately qualified by training, experience, or both, to apply diagnostic or treatment techniques and procedures for patients under the direction of a physician. Such persons who are required to have an Arizona license to practice their profession shall have the appropriate license.

Historical Note

Section R9-10-312, formerly numbered as R9-10-212, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-312 repealed, new Section R9-10-312 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-313. Administration

A. Governing authority: The governing authority shall adopt bylaws which identify the purposes of the rural general hospital and the methods of fulfilling them. The governing authority shall appoint a chief executive officer who shall be appropriately qualified for the management of the facility. The chief executive officer shall have authority and responsibility for the operation of the rural general hospital.

B. The chief executive officer shall be directly responsible for the management and operation of the rural general hospital and shall provide liaison between the governing authority and the medical staff.

1. The chief executive officer shall maintain written definitions of the rural general hospital organization, authority, responsibility and relationships, to provide the rural general hospital with administrative direction.
2. When there is a planned change of the chief executive officer or ownership, the governing authority shall notify the Department at least thirty days prior to the effective date of change. Such changes that cannot be planned in advance shall be reported in writing to the Department immediately.
3. Written admission and discharge policies which are consistent with the established purposes of the rural general hospital shall be maintained in the admitting office.
4. An employee authorized to accept patients for admission and to make administrative decisions concerning their disposition shall be available at all times.
5. Upon admission, inpatients shall be provided a suitable device or method for identification.
6. The following documents or copies shall be available in the rural general hospital:
   a. Bylaws of the governing body.
   b. Bylaws and rules and regulations of the medical staff.
   c. Policies and procedures for established rural general hospital services.
   d. Reports of inspections and reviews related to licensure for the preceding five years together with corrective actions taken.
   e. Contracts related to licensure to which the rural general hospital is bound.
   f. Appropriate documents evidencing control and ownership.
   g. A current copy of Title 9 Health Care Regulations available from the Office of the Secretary of State, which includes:

Chapter 1, Article 4	Codes and Standards Referenced
Chapter 8, Article 1	Food and Drink
Chapter 9, Articles 1,2,3	Health Care Institutions: Establishment and Modification
Chapter 10, Article 1	Health Care Institutions: Licensure
Chapter 10, Article 3	Rural General Hospital
Chapter 11, Articles 1,2	Health Care Institutions: Rates and Charges

7. Personnel
   a. Personnel records:
      i. A record of each employee shall be maintained which includes the following:
         (1) Employee's identification, including name, address and person to be notified in an emergency.
         (2) Resume of education and work experience.
         (3) Verification of valid license if required, education and training.
      ii. Payroll and attendance records for the preceding twelve month period shall be available for review by Department personnel.
      iii. Every position shall have a written description of the duties of the position.
   b. New employees shall receive orientation to familiarize them with the facility, its policies, and the responsibilities of the new employee.
   c. Continuing education programs shall be regularly provided for all nursing and dietary personnel to prepare them for their specific duties and responsibilities in the hospital. Records shall be maintained that include at least subject matter, attendance date, and location of the education program.
   d. An employee whose duties during his normal work shift require him to be awake while on the job, shall not be scheduled to work consecutive shifts.
   e. Pre-employment and annual medical screenings shall be conducted; these shall include a medical history and an appropriate tuberculosis screening test. A physical examination shall be accomplished of those persons whose medical screening indicates such need.
8. Miscellaneous
   a. There shall be no pets allowed in the patient care and food service areas of the rural general hospital. For the purposes of these regulations, seeing eye and hearing ear dogs are not considered pets.
   b. Unless bedside telephones are provided, patients shall have access to a public telephone.
   c. The person on duty and in charge of the hospital shall have reasonable access to all areas of the hospital.
   d. Reasonable privacy shall be provided for all patients.

C. The Department recognizes that emergency situations do occur in which a rural general hospital may temporarily need to exceed its licensed capacity. The medical need to admit patients in excess of licensed bed capacity as indicated by service category as shown on the then current license shall be determined by a committee or other organizational structure of the medical staff. During any period in which the hospital's

census exceeds its licensed bed capacity by category of service, it shall suspend all elective admissions to that service category. The exception afforded by this Subsection does not exempt a rural general hospital from any other requirement of this Chapter.

D. Licensed nursing personnel shall be prepared, through appropriate education or training, for their responsibilities in the provision of nursing care. This training shall include:
1. Cardiopulmonary resuscitation training
2. Basic recognition of EKG arrhythmias
3. Use of emergency equipment

Historical Note
Section R9-10-313, formerly numbered as R9-10-213, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-313 repealed, new Section R9-10-313 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-314. Medical staff

A. The rural general hospital shall have a medical staff responsible to the governing authority for the quality of medical care provided to patients and for the ethical and professional practices of its members.

B. Patients shall be admitted to the rural general hospital by a member of the medical staff in accordance with medical staff bylaws, and shall be under the general care of a physician.

C. A rural general hospital shall have at least 1 physician as an active medical staff member and at least 1 other physician as consultant or as courtesy staff who shall be active in committee functions.

D. The medical staff, subject to final action by the governing authority, shall adopt bylaws, rules and regulations, and policies for the proper conduct of its activities. The medical staff shall recommend to the governing authority, physicians and other licensed practitioners considered eligible for new and continued membership on the medical staff, as delineated in medical staff bylaws. Clinical privileges of each medical staff member shall be delineated in writing.

E. The bylaws shall state the type, purpose, composition and organization of standing committees.

F. The medical staff shall be responsible to assure the availability of inpatient and outpatient physician services in the event of an emergency.

Historical Note
Section R9-10-314, formerly numbered as R9-10-214, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-314 repealed, new Section R9-10-314 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-315. Nursing services

A. Organization
1. The rural general hospital shall have an organized nursing service to provide nursing care to meet the needs of each patient.
2. There shall be a director of nursing.
3. Administrative and patient care policies and procedures for all nursing services provided shall be developed, periodically reviewed and revised as necessary.

B. Staffing
1. The nursing department shall be adequately staffed at all times based upon the number of patients and their acuity.
   a. A registered nurse shall be on duty and in charge of the nursing service at all times.
   b. There shall be at least 1 registered nurse and at least 1 other licensed nurse or ancillary nursing personnel on duty at all times when there are inpatients.
   c. Each nursing unit shall be staffed by at least 1 registered nurse on each shift, nursing units with 25 patients or more shall have an additional licensed nurse on each shift.
   d. When there is only 1 registered nurse on duty, a registered nurse shall be on call and available to the rural general hospital within fifteen minutes.
2. A general staffing plan shall be maintained which includes individual staffing patterns for each nursing unit, and for the surgical, obstetrical, outpatient, and emergency services.

C. Patient care plans: There shall be a written patient care plan developed for each patient which is consistent with the patient's medical plan of care. Development of the plan shall be coordinated with the total health team. The plan shall reference the patient's problems and needs as well as the approaches to achieve treatment goals. The plan shall be available to all members of the patient's health team.

Historical Note
Section R9-10-315, formerly numbered as R9-10-215, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-315 repealed, new Section R9-10-315 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-316. Surgical services

A. Rural general hospitals are not required to provide surgical services.

B. Rural general hospitals that provide surgical services shall meet the following requirements:
1. The rural general hospital shall have at least 1 operating room.
2. A roster specifying the surgical privileges of each physician shall be kept in the operating room or suite.
3. The medical staff shall establish policies specifying the surgical procedures which will require a second physician as assistant in surgery.
4. A chronological register of surgical operations performed shall be maintained in the surgical suite.
5. Except in a documented emergency, a history shall be taken and physical examination shall be performed on every patient prior to surgery.
6. There shall be policies and procedures for the immediate post-operative care.
7. The surgical suite shall be supervised by a registered nurse.
8. The operating room(s) and support services shall be located to prevent through traffic.
9. General anesthesia shall be administered by an anesthesiologist or an anesthetist.
10. The recovery room shall be supervised by a registered nurse who may be the surgical services supervisor.
11. There shall be available a current listing of all types of surgical procedures offered in the hospital. The current edition of the American Medical Association Procedural Terminology shall be used as a guide when preparing this list.
12. Policies shall be adopted regarding the content of, and timing for, anesthetic follow-up notes.

13. When surgical procedures are scheduled to be performed under general anesthesia, at least 1 other physician shall be on call and available to the rural general hospital within 20 minutes.

Historical Note
Section R9-10-316, formerly numbered as R9-10-216, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-316 repealed, new Section R9-10-316 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-317. Dietetic services

A. Organization
1. The rural general hospital shall have an organized dietetic service under the direction of a qualified food service director who has authority and accountability for the dietetic services.
2. Each rural general hospital shall have at least 1 dietitian employed on either a full-time, part-time, or consultant basis to direct the nutritional aspects of patient care and to advise on food preparation and services.
3. There shall be written policies and procedures established for all dietetic services.

B. Staffing
1. Staffing of dietetic services shall be maintained at levels to assure adequate numbers of dietitians, technical, clerical, and other appropriately qualified personnel to complete all dietary functions.
2. Time schedules and job assignments shall be on file.

C. Facilities: Adequate space, equipment, and supplies shall be provided for the efficient, safe and sanitary receiving, storage, refrigeration, preparation and service of food.

D. Nutritional care
1. A current diet manual shall be readily available to physicians, nursing and food service personnel.
2. Pertinent observations and information related to special diets, patient's food habits and dietetic treatment shall be recorded in the patient's medical record.
3. A written order for modified diet prescriptions as recorded in the patient's medical record shall be kept on file in the dietetic services office throughout the duration of the order.

E. Sanitation: Food service sanitation shall be maintained in accordance with the Department's regulations contained in A.C.R.R. Title 9, Chapter 8, Article 1, "Food and Drink".

Historical Note
Section R9-10-317, formerly numbered as R9-10-221, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-317 repealed, new Section R9-10-317 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-318. Emergency services

A. A rural general hospital is not required to staff or equip a full-time emergency department, but necessary emergency medical services shall be provided in a designated area of the rural general hospital. The rural general hospital shall have procedures whereby the ill or injured person will be assessed and treated or referred to an appropriate facility.

B. Emergency services shall be provided to any person in need of them. If the hospital offers only a partial range of services and elects to transfer the patient for further care, essential lifesaving measures and emergency procedures shall be instituted that will minimize aggravation of the condition during transportation. A patient shall be transferred only to a receiving institution that has consented to accept the patient. A record of the immediate medical problem and treatment provided shall accompany the patient.

C. There shall be written policies approved by the medical staff and adopted by the governing authority establishing the type of treatment to be carried out by the emergency service. These written policies shall provide for transfer to facilities offering specialized care.

D. There shall be a physician responsible for the overall medical direction of emergency services.

E. The emergency services of a rural general hospital shall maintain the following minimum staffing requirements:
1. A current roster of physicians on call.
2. A registered nurse available to the rural general hospital within 15 minutes.
3. A laboratory technician on call.
4. A radiologic technician on call.

F. Resuscitative and monitoring equipment and supplies shall be readily available for emergency services.

G. An emergency cart containing the drugs and emergency equipment required for the immediate care of emergencies shall be readily available. The emergency cart shall be inventoried on each shift, as well as after each use, by a designated person unless it is in a sealed unit and the seal is intact. Written documentation of this inventory shall be maintained.

Historical Note
Section R9-10-318, formerly numbered as R9-10-222, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-318 repealed, new Section R9-10-318 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-319. Disaster preparedness

A. Disaster plan: There shall be a written plan of operation with procedures to be followed in the event of a disaster. The plan shall be developed in two phases:
1. Phase one -- Internal disasters such as fire, gas explosion, etc. Policies and procedures shall include:
   a. Notification of personnel and assignment of responsibilities.
   b. Instructions regarding the location and use of fire alarm systems and fire fighting equipment.
   c. Provision for each type of internal disaster (fire, bomb scare, etc.).
   d. Provisions for evacuation, including priorities for evacuation and disposition.
   e. Management of casualties.
   f. Emergency feeding plan.
2. Phase two -- External disasters such as mine explosion, bus accidents, flood, earthquakes, etc. Policies and procedures shall include:
   a. Notification of personnel and assignment of responsibilities.
   b. Communications with other facilities.
   c. Unified medical command.
   d. Establishment of a triage unit and its location.
   e. Transfer of patients.
   f. Method of identifying patients.
   g. Establishment of an emergency treatment record.
   h. Public information center.
   i. Security.
   j. Method to obtain necessities (water, food, etc.).

k. Determination of availability of beds, blood, medical supplies, etc.
l. Emergency feeding plan.

B. Disaster and fire drills: As required by R9-1-412(3), Life Safety Code, at least twelve fire drills shall be held each year. They shall be conducted at irregular intervals and at least four times on each shift. At least 1 disaster drill shall be held on each shift each year. Fire and disaster drills may be combined and may accommodate more than 1 shift.

C. Policies shall be established for obtaining sufficient personnel to staff the rural general hospital during post-emergency or disaster periods.

Historical Note

Section R9-10-319, formerly numbered as R9-10-223, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-319 repealed, new Section R9-10-319 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-320. Environmental services

A. A committee composed of members of the medical staff, nursing staff, laboratory staff, and other appropriate persons shall develop policies and procedures for investigating, controlling and preventing infections in the rural general hospital and shall monitor staff performance in implementation of these procedures. All cases of reportable diseases shall be reported in accordance with applicable rules and regulations adopted by the Department. There shall be a method of control used in relation to sterilization of supplies and water and a written policy requiring sterile supplies to be reprocessed at specified time periods.

B. The rural general hospital shall be kept clean, free of insects, rodents, litter, and rubbish. All areas shall be regularly and appropriately cleaned in accordance with administrative policies and procedures.

C. The rural general hospital physical plant, including equipment, shall be periodically inspected and, where appropriate, tested, calibrated, serviced or repaired to assure that all equipment is free of fire and electrical hazards and is functioning properly. Records shall be maintained to assure that appropriate inspections and maintenance of equipment are periodically accomplished by qualified personnel.

D. There shall be available at all times clean linen essential to the proper care and comfort of the patients. Linens shall be handled, stored, processed and transported in a manner which will prevent the spread of infection.

E. All potentially hazardous wastes such as waste from isolation rooms and disposable materials contaminated with secretions, excretions or blood, patient care and laboratory animal care wastes, laboratory wastes and the like shall be sterilized by autoclaving and buried in a Department approved sanitary landfill or may be disposed of by incinerating in an incinerator approved by the Air Pollution Control Officer having jurisdiction. If only 1 autoclave is available and an incinerator is not available, the waste shall be double bagged, clearly marked and shall be taken to a Department approved landfill. The operator of the landfill shall be notified and immediate burial assured. Provisions of A.C.R.R. Title 9, Chapter 8, Article 4 pertaining to disposal of such material shall be observed.

F. When oxygen is being used, the following precautions shall be taken:
1. A warning sign shall be placed at each entrance to the room.
2. Ash trays, matches, and other smoking material shall be removed from the room.
3. Oxygen tanks shall be secured at all times. Additional precautions shall be taken in accordance with the Life Safety Code adopted by reference in R9-1-412(B) and the Inhalation Anesthetics Code adopted by reference in R9-1-417(A).
4. Hydrocarbon greases shall not be used.

G. Electrical safety:
1. Extension cords shall not be used except for maintenance services.
2. Equipment and appliances including radios and television sets, which use electricity as a source of energy shall be grounded.
3. Additional precautions shall be taken in accordance with the National Electrical Code adopted by reference in R9-1-412(E).

H. There shall be written policies concerning syringe and needle storage, handling and disposal.

I. Water supply shall be in accordance with the Department's regulations contained in A.C.R.R. Title 9, Chapter 8, Article 2.

J. Sewage systems shall be in accordance with the Department's regulations contained in A.C.R.R. Title 9, Chapter 8, Article 3.

Historical Note

Section R9-10-320, formerly numbered as R9-10-231, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-320 repealed, new Section R9-10-320 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-321. Medical records services

A. There shall be a medical records service under the direction of a designated person and with adequate staff and facilities to perform all required functions. If the designated person is not qualified in medical records management, he shall receive consultation from a qualified person.

B. A medical record shall be established and maintained for every person receiving treatment as an inpatient, outpatient, or on an emergency basis in any unit of the rural general hospital. The records shall be available to other units engaged in care and treatment of the patient.

C. Only authorized personnel shall have access to the records.

D. Medical record information shall be released only with the written consent of the patient, the legal guardian, or in accordance with law.

E. In rural general hospitals that have designated psychiatric or substance abuse units, confidentiality of medical records shall be maintained as required by A.R.S. § 36-509 and applicable regulations.

F. For licensing purposes medical records shall be readily retrievable for a period of not less than three years, except that A.R.S. § 36-343 requires retention of vital records and statistics for ten years.

G. The original or signed copy of all clinical reports shall be filed in the medical record.

H. Medical records shall be indexed to facilitate continuity of care, acquisition of statistical medical information and retrieval of records for research or administrative action.

I. Within 48 hours of admission, a current or updated history and physical examination shall be in the record.

J. When a patient is re-admitted within 30 days for the same problem, there shall be at least a reference to the previous history by an interval note.

K. Histories and physicals shall be written by members of the medical or the house staff. When authorized by medical staff bylaws, physician assistants and nurse practitioners may write or dictate medical histories and results of physical examinations. A physician's signature shall be required on each page of the record which bears a notation made by a physician assistant or nurse practitioner under his direction.

L. All entries in the record must be dated and signed or initialed by the person making the entry. If initials are used, a method must be established to identify authorship.

M. Medical records of discharged patients shall be completed within the time limit established by the medical staff.

N. Inpatient medical records shall contain the following information, if applicable:
1. Patient's identification sheet, including name, address, date of birth, sex, person to be notified in an emergency, and an unique identifying number.
2. History and physical examination.
3. Physician's orders and progress notes.
4. Laboratory and diagnostic reports.
5. Nursing notes.
6. Patient care plans.
7. Medication and treatment record.
8. Admitting diagnosis.
9. Disposition and discharge diagnosis.
10. Record of informed consent.
11. Discharge summary.

O. The outpatient's medical record shall be accessible:
1. In outpatient departments that are organized by clinics, the following information shall be available:
   a. Patient's identification sheet.
   b. History and physical examination.
   c. Physician's orders.
   d. Any laboratory and other diagnostic tests, diagnosis and treatment.
   e. Disposition.
2. If outpatient services are provided in other than an organized outpatient clinic, the following information shall be available:
   a. Patient's identification.
   b. That information pertaining to the patient's chief complaint including, but not limited to, physician's orders, treatment or service provided, and disposition.

P. The emergency services record shall contain the following:
1. Patient's identification.
2. Record of any treatment patient received prior to arrival.
3. History of disease or injury.
4. Physical findings.
5. Laboratory and x-ray reports, if applicable.
6. Diagnosis.
7. Record of treatment.
8. Disposition.
9. Name of physician who ordered emergency treatments.

Q. All deaths, abortional acts, post-mortem procedures, and births shall be reported in accordance with A.C.R.R. Title 9, Chapter 19.

R. If a facility ceases operation, there shall be an arrangement for preservation of records to ensure compliance with these regulations. The Department shall be notified, in writing, concerning the arrangements.

S. Symbols or abbreviations used in the medical record shall be approved by the medical staff and a current copy maintained at each nursing unit and in the medical record department.

Historical Note
Section R9-10-321, formerly numbered as R9-10-232, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-321 repealed, new Section R9-10-321 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-322. Laboratory services

A. Minimum capability:
1. There shall be within the rural general hospital the capability of providing clinical laboratory services required to support emergency services.
2. There shall be arrangements for the provision of clinical and anatomical pathology services necessary to meet the needs of hospitalized patients.
3. Clinical laboratory services may be provided by another hospital laboratory, an independent clinical laboratory or an out-of-state laboratory providing the following conditions are met:
   a. The contracting laboratory is licensed by the Department or, in the case of out-of-state clinical laboratories, licensed by the United States Government, to perform the contracted laboratory services.
   b. The conditions, procedures and type of examinations performed by the contracting laboratory or hospital for the rural general hospital shall be in writing and available in the rural general hospital.

B. Administration
1. Clinical laboratory services shall be under the medical direction of a physician with training and experience in clinical laboratory services, or a person who holds a doctoral degree from an accredited institution with a chemical, physical or biological science as his major subject and who is qualified to perform at least 1 of the technical services provided by the laboratory. Anatomical pathology service shall be provided by a pathologist.
2. A qualified person shall be appointed to be in charge of the laboratory in the absence of the director.
3. At least 1 qualified laboratory technician or technologist shall be on duty or on call at all times.

C. Examination of specimens, written requests, reports of results, retention of test records:
1. Except as otherwise provided, laboratory personnel shall examine specimens only at the request of a physician authorized to practice medicine and surgery or other persons permitted by law to use the findings of laboratory examinations or at the request of the Department for the purpose of quality control and proficiency testing.
2. Results of tests shall be reported to the physician and entered in the patient's chart. No clinical interpretation, diagnosis, prognosis or suggested treatment shall appear on the laboratory report form except that a report made by a physician may include such information.
3. All specimens received by the laboratory shall be tested on the premises or may be forwarded for analysis to another laboratory licensed under A.R.S. Title 36, Chapter 4.1, Article 2 or licensed as part of a rural general hospital or exempted by A.R.S. § 36-461(4). Specimens submitted for proficiency testing shall be analyzed on the premises by regularly assigned personnel using the laboratory's routine methods.
4. When the laboratory performing the analysis is other than the laboratory which initially received the specimen, the report shall include the name, address, and name of the director of the laboratory actually performing the analysis.

D. Quality control program:

1. Each laboratory director shall establish and file with the Department a detailed description of the services to be provided by the laboratory and of a quality control program that is acceptable to the Department and meets the standard specified in R9-14-108. It is the responsibility of the laboratory director to assure that the laboratory is operated in accordance with its approved quality control program.
2. Each laboratory shall participate successfully in a proficiency testing program provided by the American Association of Bioanalysts or the College of American Pathologists for each authorized specialty and subspecialty. Records of such testing shall be kept for two years and shall be available for examination by representatives of the Department. Laboratory personnel shall enter the date and time of receipt of samples, results and other information as may be required on forms provided by the proficiency testing service.
3. Each laboratory shall participate successfully in a Department operated proficiency testing program if the laboratory seeks authorization in a specialty or subspecialty for which proficiency testing is not available under paragraph (D)(2) or if the Department needs additional assurance of the laboratory's proficiency. Such testing may be carried out during on-site inspections or by submittal of specimens by mail. Regularly assigned personnel shall examine samples using the laboratory's routine methods. The laboratory will be tested only in specialties or subspecialities for which an authorization has been issued by the Department. Proficiency test samples shall be tested within the time required under conditions of normal laboratory operation. Laboratory personnel shall enter the date and time of receipt of samples, results and other information as may be required on forms provided by the Department.

E. Sanitation and safety requirements: All laboratories shall be maintained and operated in a manner which prevents undue physical, chemical and biological hazards to hospital patients, employees or other members of the community and in accordance with standards specified in R9-14-109.

F. Maintenance, availability, retention of records:
1. Records of observations shall be made concurrently with the performance of each step in the examination of specimens. The actual results of all control procedures shall be recorded.
2. Records shall identify the individual performing the examination. Such records as well as duplicate copies of laboratory reports shall be retained in the laboratory area for a period of at least 1 year after the date the results are reported.
3. A.R.S. § 25-103.06 requires that copies of premarital serology results be retained for five years.

G. Blood services: Hospitals shall have facilities adequate for the procurement, storage and transfusion of blood and blood components. Records of the donor and recipient of all blood handled shall be available. All transfusion reactions occurring in the hospital shall be investigated by the medical staff and an incident report shall be prepared.

Historical Note

Section R9-10-322, formerly numbered as R9-10-233, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-322 repealed, new Section R9-10-322 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-323. Pharmaceutical services

A. The rural general hospital shall maintain pharmaceutical services which comply with A.R.S. Title 36, Chapter 9, and A.R.S. Title 32, Chapter 18 and all applicable regulations adopted by the Board of Pharmacy pursuant thereto.

B. There shall be a pharmacy and therapeutics committee composed of a member of the medical staff, a pharmacist, and other appropriate personnel.

C. Administration of drugs:
1. Procedures shall be established to assure that drugs are administered only by persons authorized by state statutes and regulations.
2. Procedures shall be established to ensure that drugs are checked against physician's orders, that the patient is identified prior to administration of the drug, that each patient has an individual medication record, and that the dose of a drug administered to that patient is properly recorded therein by the person who administers the drug.
3. Drugs and biologicals shall be administered as soon as possible by a physician or a licensed nurse. Preparation for administration shall not be interpreted as dispensing.

Historical Note

Section R9-10-323, formerly numbered as R9-10-234, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-323 repealed, new Section R9-10-323 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-324. Rehabilitation services

A. For purposes of this Section rehabilitation services include physical therapy, occupational therapy, speech therapy or audiology services.

B. The following provisions shall be met in rural general hospitals that provide rehabilitation services:
1. Rehabilitation services shall be provided by a qualified therapist only when ordered or upon referral by a physician. Rehabilitation services may be provided by qualified aides and assistants only when a qualified therapist is on the premises.
2. There shall be written administrative and patient care policies and procedures for each of the rehabilitation services offered.
3. There shall be a written plan for each patient indicating the modality or type of treatment provided and the frequency of treatment. This plan shall be based on the written order of a physician.
4. There shall be written documentation in the patient's medical record of the rehabilitation services provided.

Historical Note

Section R9-10-324, formerly numbered as R9-10-235, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-324 repealed, new Section R9-10-324 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-325. Quality assurance

A. Each rural general hospital shall have a quality assurance program conducted in accordance with A.R.S. § 36-445. A record of such activities shall be maintained.

B. A discharge planning program shall be established to provide for the transfer of information between hospital and other health facilities or agencies to facilitate continuity of care.

Periodic review and evaluation of the program shall be conducted by a committee established for this purpose.

Historical Note
Section R9-10-325, formerly numbered as R9-10-236, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-325 repealed, new Section R9-10-325 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-326. Radiology services

A. A rural general hospital shall have within the hospital as a minimum the capability of providing emergency diagnostic radiology services.
B. A physician shall be responsible for the medical direction of the radiology department.
C. A radiologic technician shall be on duty or on call at all times.
D. There shall be a radiologic procedure manual available to radiology services personnel.
E. X-ray examinations shall be performed only when ordered by a person authorized by law. Request for x-ray shall contain a concise statement of the reason for the examination.
F. The radiology department shall be staffed, equipped and operated in accordance with A.R.S. Title 30, Chapter 4 and regulations adopted thereunder.

Historical Note
Section R9-10-326, formerly numbered as R9-10-237, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-326 repealed, new Section R9-10-326 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-327. Respiratory care services

Rural general hospitals that provide respiratory care services shall meet the following provisions:

1. Respiratory care services shall include therapeutic procedures and may include diagnostic procedures.
2. A physician shall be responsible for the medical direction of the respiratory care unit or department.
3. Respiratory care services shall be provided in accordance with the written order of a physician. The order shall state the modality to be used, the type, frequency and duration of treatment and type and dose of medication including dilution ratio.
4. Reports of respiratory care services shall be made a part of the patient's medical record.
5. Respiratory therapy shall be administered by qualified personnel.

Historical Note
Section R9-10-327, formerly numbered as R9-10-241, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-327 repealed, new Section R9-10-327 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-328. Special care units

Rural general hospitals shall not have intensive care or cardiac care units.

Historical Note
Section R9-10-328, formerly numbered as R9-10-242, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-328 repealed, new Section R9-10-328 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-329. Obstetrical services

In rural general hospitals providing obstetrical services, the following shall apply:

1. There shall be a registered nurse in charge of the delivery room and on duty there whenever patients are in the unit.
2. There shall be policies and procedures adopted by the medical staff in accordance with the Standards for Obstetric-Gynecologic Hospital Services adopted by reference in R9-1-413(A) which provides for:
   a. Mixing of non-maternity patients with maternity patients.
   b. The use of operating rooms for delivery.
   c. Surgical procedures performed in the delivery room.
3. Designated delivery rooms shall be provided with necessary supplies and equipment.
4. Policies for the administration of oxytocic drugs, analgesics, and anesthetics shall be written.
5. Equipment and supplies for anesthesia shall be readily available.
6. Resuscitation equipment shall be available.
7. A warming device that is free from fire or electrical hazards and capable of minimizing neonatal heat loss shall be available.
8. Every newborn shall be identified by two reliable methods before removal from the delivery room other than in an emergency.
9. A chronological delivery room record shall be maintained.
10. Antepartum and postpartum care shall be under the supervision of a registered nurse.
11. Newborn nursery
    a. Policies and procedures shall be adopted in accordance with the standards and recommendations for Hospital Care of Newborn Infants adopted by reference in R9-1-413(B).
    b. A registered nurse shall be in charge of the nursery at all times.
    c. A nursery shall be provided for the care of newborns and shall not be used for any other purpose.
    d. A room in which "rooming-in" is practiced shall not be considered a nursery unless more than two mothers are accommodated in which case all requirements for newborn nurseries shall apply.
    e. An individual bassinet shall be provided for each newborn and each newborn shall have separate equipment and supplies.
    f. The use of common bathing or dressing areas is prohibited. All bathing, diaper changing, and treatments shall be carried out in the bassinet or on the newborn's individual shelf or drawer.
    g. Accurate scales shall be provided.
    h. Any newborn born outside of the hospital and any newborn suspected of having an infection or who has been exposed to actual or potential infection shall be properly isolated. The decision to transfer a newborn from the main nursery to isolation may be made by the nurse in charge of the main nursery in an emergency.
    i. Only persons specified by hospital rules and regulations shall be admitted to any nursery.

j. Containers shall be provided for soiled diapers to ensure proper disposal.
k. Underwriters Laboratory-approved isolettes shall be available.
l. The use of a rack or bassinet stand which holds more than 1 bassinet is prohibited.
m. Oxygen, oxygen equipment and suction equipment adapted to the use of newborn infants shall be available. An oxygen analyzer shall be available.
n. Formula shall be prepared in an appropriate isolated area.
o. Traffic in the nursery shall be closely supervised by the registered nurse in charge.
p. Sanitized nursery linens or disposable linens shall be used.
q. Whenever two or more infants in a nursery exhibit symptoms of a communicable illness, the incident shall be reported to the Department as required by A.C.R.R. Title 9, Chapter 6.

12. Hospitals that do not provide obstetrical services but have only emergency obstetrical capabilities shall have:
a. A designated area within the hospital where emergency obstetrical services may be performed.
b. Necessary supplies and equipment to provide emergency obstetrical services.
c. At least 1 Underwriter Laboratory-approved isolette.

Historical Note
Section R9-10-329, formerly numbered as R9-10-243, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-329 repealed, new Section R9-10-329 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-330. Pediatric services
Rural general hospitals with a designated pediatric unit shall have distinct facilities for the care of children. There shall be facilities and procedures for the isolation of children with communicable diseases.

1. Policies shall be established to cover conditions under which parents or guardians may stay with their child.
2. The standards for the Care of Children in Hospitals adopted by reference in R9-1-413(C) are recommended as a guide for pediatric services in hospitals.

Historical Note
Section R9-10-330, formerly numbered as R9-10-244, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-330 repealed, new Section R9-10-330 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-331. Social services
When a rural general hospital provides social services the following conditions shall be met:

1. There shall be policies and procedures relating to the staff and functions of the department.
2. Personnel
a. The social service department shall be under the direction of a social worker and shall have adequate staff and facilities to perform all required functions; or
b. Social services shall be provided by a designated person who shall receive consultation from a social worker in accordance with a written agreement; or
c. Social services shall be provided by referral, based on established written procedures, to appropriate social agencies.
3. Social services to patients shall be initiated by physician referral or by request of patient, family member or guardian.
4. Social services information shall be recorded. Policies and procedures shall be established by the Department with approval of the medical staff which specify the type and extent of this information to be placed in the medical record.
5. Facilities shall be provided which are accessible to patients and staff and which assure privacy for interviews.

Historical Note
Section R9-10-331, formerly numbered as R9-10-245, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-331 repealed, new Section R9-10-331 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-332. Rural general hospital physical plant

A. Physical plant -- existing facilities
1. The physical plant of all rural general hospitals licensed prior to adoption of these regulations shall meet the requirements of the sections applicable to existing hospitals in the Life Safety Code adopted by reference in regulation R9-1-412(B).
2. Appropriate drawings shall be submitted to the Department for any additions, alterations, or modifications to the physical plant before work is undertaken.
3. Alterations to the existing physical plant shall conform to new construction standards.

B. Physical plant -- new construction
1. All new construction shall meet the minimum requirements of the applicable provisions of all codes and standards adopted by reference in R9-1-412 in accordance with their scope and applicability as specified in regulation R9-1-411.

2. Unless otherwise specified in this Section, patient rooms in newly constructed rural general hospitals shall conform to the following minimum and maximum sizes:

Type of Accommodations	Minimum (Sq. Ft.)	Minimum (Sq. M.)	Maximum* (Sq. Ft.)	Maximum* (Sq. M.)
Private	100	9.29	150	13.94
2 Bed	160	14.86	230	21.37
3 Bed	240	22.30	310	28.80
4 Bed	320	29.73	390	36.23

* Exception: Maximum areas may be exceeded if the number of beds is limited by the configuration of the room, and when approval has been obtained from the Department.

3. Capacity of patient rooms (excluding special care units) shall not exceed four beds.
4. All patient room doors required to be self-closing by the Uniform Building Code adopted by reference in R9-1-412(A) shall be equipped with a hold-open device. The device, upon activation of the fire alarm system, automatic fire extinguishing system and related products of combustion detectors, shall allow the door to close automatically.

C. All new and existing rural general hospitals shall meet the following physical plant and safety factors:

1. Multi-bed rooms shall be designed and arranged to permit no more than two beds side by side parallel to the window wall with at least three feet (91 cm) between beds and three feet (91 cm) between bed and wall except at the head of the bed.
2. All patient rooms shall be outside rooms. The window area in each patient room shall be at least 1/8 of the floor area. Suitable window shades or drapes shall be provided as a means of controlling light.
3. Each bed shall have a nurse call system which conforms to the standard adopted by reference in R9-1-412(F).
4. Each patient room shall be numbered. The Department shall be notified when room numbers are changed.
5. Rural general hospitals licensed prior to the adoption of these regulations shall have a minimum ratio of 1 toilet, 1 lavatory and 1 tub or shower for each ten beds on each floor.
6. All toilet rooms, bathrooms, utility rooms and janitor's closets shall have mechanical ventilation providing a minimum number of air changes per hour as specified in the code adopted by reference in R9-1-412(F).
7. There shall be adequate storage spaces or alcoves to store wheelchairs, walkers, and similar equipment when not in use. No corridors or stairwells shall be used for storing such equipment.
8. There shall be adequate space for the preparation, cleaning, sterilization and storing of supplies and equipment.
9. There shall be at least 1 isolation room for isolation of patients, with a communicable disease, for each 100 beds or fraction thereof. The isolation room shall contain a private toilet, shower/tub and lavatory facilities.
10. Separate adequate storage space for each patient shall be provided within the patient's room.
11. Newborn nurseries shall have at least 24 square feet (2.23 sq. M) of floor space for each bassinet with two feet (61 cm) between bassinets.
12. Pediatric nurseries shall have at least 40 square feet (3.72 sq. M) of floor space for each bassinet.
13. Pediatric beds shall have the same space requirements as adult patient beds.
14. Items such as drinking fountains, telephone booths, vending machines, furniture, and medical equipment shall be located so that they do not reduce the required width of exit doors.
15. No door which is required to be fire rated shall be held open except with a device approved by the codes adopted by reference in R9-1-412.
16. Patient beds licensed after June 19, 1964 shall maintain the following minimum square footage per bed:
    a. One bed rooms -- 100 square feet (9.23 sq. M) per bed.
    b. Multi-bed rooms -- 80 square feet (7.43 sq. M) per bed.
17. Multi-patient rooms licensed at 70 square feet (6.50 sq. M) per bed before and continuously since June 19, 1964 may retain the 70 square feet (6.50 sq. M) per bed.

Historical Note
Section R9-10-332, formerly numbered as R9-10-246, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-332 repealed, new Section R9-10-332 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-333. Rates and charges

The current schedule of rates and charges shall be posted in accordance with R9-11-114(H) and R9-10-1734.

Historical Note
Section R9-10-333, formerly numbered as R9-10-247, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Former Section R9-10-333 repealed, new Section R9-10-333 adopted effective February 4, 1981 (Supp. 81-1).

R9-10-334. Repealed

Historical Note
Section R9-10-334, formerly numbered as R9-10-249, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Repealed effective February 4, 1981 (Supp. 81-1).

R9-10-335. Repealed

Historical Note

Section R9-10-335, formerly numbered as R9-10-250, renumbered as an emergency effective February 22, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Adopted effective June 14, 1979 (Supp. 79-3). Repealed effective February 4, 1981 (Supp. 81-1).

ARTICLE 4. SPECIAL HOSPITALS

R9-10-401. Reserved

R9-10-402. Reserved

R9-10-403. Reserved

R9-10-404. Reserved

R9-10-405. Reserved

R9-10-406. Reserved

R9-10-407. Reserved

R9-10-408. Reserved

R9-10-409. Reserved

R9-10-410. Reserved

R9-10-411. General

A. Special hospitals shall observe R9-10-211.

B. Special hospitals include but are not limited to:

1. Hospitals limiting admissions to patients requiring care or treatment for substance abuse.
2. Hospitals limiting admissions to patients requiring services for the terminally ill.
3. Hospitals limiting admissions to patients requiring psychiatric services.
4. Hospitals limiting admissions to patients requiring reconstructive surgery or services in rehabilitation medicine.
5. Hospitals limiting admissions to patients requiring obstetrical or gynecological services.
6. Hospitals limiting admissions to patients requiring services for the treatment of pain or stress.

C. Special hospitals under common ownership with a general hospital shall not be required to maintain independent services or functions if such services or functions are provided by the general hospital.

Historical Note

Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-412. Definitions

Section R9-10-212 is adopted with the following additions:

1. "Detoxification" means the systematic reduction of physical dependence upon alcohol or other drugs (excluding dependence on methadone or other maintenance drugs) by use of therapeutic procedures, which may include medication, rest, diet, counseling, or medical supervision.
2. "Drug administration" means the giving of a single dose of medication to a specific patient as a result of an order of a physician or other authorized medical practitioner.
3. "Drug dispensing" means the issuing of 1 or more doses of a medication in a suitable container, with appropriate label for subsequent administration to or use by a patient.
4. "Gynecologist" means a physician specialist for the diagnosis and treatment of the female generative organs. He may also be an obstetrician.
5. "Obstetrician" means a physician specialist for treatment of women during pre-natal, natal, and post-natal periods. He may also be a gynecologist.
6. "Patient activity program" means a level of therapeutic revitalization and assessment of needs, interests, and activities for the re-enforcement and maintenance of health and well-being of the patient.
7. "Physiatrist" means a physician specialist for physical medicine and rehabilitation.
8. "Physician specialist" means a physician who,
   a. Is a diplomate of the appropriate American Board or Osteopathic Board, or
   b. Is a fellow of the appropriate American Specialty College or a member of the Osteopathic Specialist College, or
   c. Has been notified of the admissibility for examination by the appropriate American Board or Osteopathic Board, or has evidence of completion of an appropriate qualifying residency approved by the American Medical Association or the American Osteopathic Association and has not lost his eligibility for admissibility to the examination.
9. "Psychiatric services" means the management, evaluation, diagnosis, treatment and prevention of mental illness.
10. "Psychiatrist" means a physician specialist for the diagnosis and treatment of mental diseases and disorders.
11. "Psychologist" means a person certified under provision of A.R.S. Title 32, Chapter 19.1.
12. "Services for the terminally ill" means a program of palliative care for patients with terminal illness and treatment of the patient's concurrent medical conditions on an inpatient, day care or outpatient basis and may involve emotionally supportive care to the patient and his family, home health services and other social and health related services.
13. "Substance abuse" means the chronic, habitual or compulsive use of alcohol, prescription or non-prescription drugs or intermittent or extended use of alcohol or such drugs resulting in impairment to physical health, mental faculties, social or economic functioning of the individual.

Historical Note

Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-413. Administration

Special hospitals shall comply with the requirements of R9-10-213. In addition, special hospitals that limit admissions to patients requiring services for the terminally ill shall be exempt from R9-10-213(B)(9)(a); however, pets shall not be allowed in the food service area.

Historical Note

Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-414. Medical staff

Special hospitals shall comply with the requirements of R9-10-214 with the following additions:

1. Physical examinations are required at least annually for patients residing in special hospitals for more than 12 months.
2. Special hospitals limiting admissions to patients requiring obstetrical and gynecological services shall have at least 1 medical staff member qualified as a physician specialist in obstetrics or gynecology.
3. Special hospitals limiting admissions to patients requiring psychiatric services shall have at least a majority of the active medical staff members qualified as physician specialists in psychiatry.
4. Special hospitals limiting admissions to patients requiring services in rehabilitation medicine shall have at least 1

medical staff member qualified as a physician specialist in rehabilitation medicine.

5. Special hospitals limiting admissions to patients requiring services for the terminally ill shall have a medical director who is responsible for the overall coordination of the medical care to ensure the adequacy and appropriateness of the medical services provided to patients and the implementation of a program providing ongoing emotional support to staff and volunteers.
6. The medical staff of special hospitals shall consist of two or more physicians.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-415. Nursing services

Special hospitals shall comply with the requirements of R9-10-215 except that:

1. The director of nurses shall have education and experience in the special services provided by the hospital.
2. In special hospitals not offering emergency or obstetrical services, there shall be at least 1 registered nurse and at least 1 other ancillary nursing personnel on duty at all times when there are inpatients.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-416. Surgical services

Special hospitals that provide surgical services shall comply with the requirements of R9-10-216.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-417. Dietetic services

A. Special hospitals shall comply with the requirements of R9-10-217 with the following additions.

B. Special hospitals limiting admissions to terminally ill patients shall meet the following requirements:

1. Each patient's nutritional needs and wants shall be evaluated on a daily basis.
2. A selective menu shall be available to patients.
3. Between meal snacks and bedtime nourishment shall be available to patients.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-418. Emergency services

A. There shall be written policies for the provision of emergency care to patients receiving treatment within the hospital.

B. Special hospitals that provide outpatient emergency services shall comply with the requirements of R9-10-218.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-419. Disaster preparedness

Special hospitals shall comply with the requirements of R9-10-219.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-420. Environmental services

Special hospitals shall comply with the requirements of R9-10-220.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-421. Medical records

In addition to the requirements of R9-10-221 special hospitals shall comply with the following:

1. Special hospitals limiting admissions to patients requiring psychiatric services shall include in the medical record:
   a. A treatment plan shall include patient goals, treatment goals, treatment to be provided, and time intervals in which treatment is to be reviewed. The plan shall be annotated to reflect the results of treatment.
   b. A report of neurological examination.
   c. A report of a psychiatric evaluation.
   d. A report of social services, if any.
   e. A report of required physical examinations.
2. Special hospitals that limit admissions to patients requiring reconstructive surgery or services in rehabilitation medicine shall include the following information in the medical record:
   a. A treatment plan including patient goals, treatment goals, treatment to be provided, time intervals in which treatment is reviewed, and measures to be used to assess the effects of the treatment.
   b. Report of an evaluation by a physiatrist or other properly qualified physician specialist.
   c. Prosthetic or orthotic evaluation and reports, if applicable.
3. Special hospitals that limit admission to patients requiring services for the terminally ill shall include the following information in the medical record:
   a. Record of home care treatment, if applicable.
   b. Record of day care treatment, if applicable.
   c. Record of services provided to family, if applicable.
   d. Social service reports.
   e. Activities plan.
4. Special hospitals that limit admission to patients requiring obstetrical and gynecological services shall include the following information in the medical record:
   a. A copy of the pre-natal record, if available.
   b. A pre-natal examination updated within 24 hours of admission may substitute for the required physical examination.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-422. Laboratory services

A. Special hospitals that provide outpatient emergency services, obstetrical services, or surgical services shall comply with the requirements of R9-10-222.

B. Special hospitals that do not provide emergency, obstetrical or surgical services shall provide laboratory services on the premises or by agreement with a licensed laboratory. The laboratory service available by agreement shall be appropriate to meet the needs of hospitalized patients.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-423. Pharmaceutical services

Special hospitals shall comply with the requirements of R9-10-223.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-424. Rehabilitation services

Special hospitals that elect to provide rehabilitation services shall comply with the requirements of R9-10-224.

1. Special hospitals limiting admissions to patients requiring psychiatric services shall provide occupational therapy and a patient activity program.
2. Special hospitals limiting admission to patients with terminal illness shall provide physical therapy and a patient activity program.

3. Special hospitals that limit admission to patients requiring reconstructive surgery or services in rehabilitation medicine shall provide rehabilitation services and comply with R9-10-224.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-425. Quality assurance
Special hospitals shall comply with the requirements of R9-10-225.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-426. Radiology services
A. Special hospitals that provide outpatient emergency or surgical services shall comply with the requirements of R9-10-226.
B. Special hospitals that do not provide emergency or surgical services shall nevertheless have radiologic services available on the premises or by agreement.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-427. Respiratory care services
Special hospitals shall comply with the requirements of R9-10-227.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-428. Special care units
Special hospitals shall comply with the requirements of R9-10-228.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-429. Obstetrical services
Special hospitals shall comply with the requirements of R9-10-229.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-430. Pediatric services
Special hospitals shall comply with the requirements of R9-10-230.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-431. Social services
Special hospitals shall comply with the requirements of R9-10-231. In addition, social services shall be provided in special hospitals which limit their admissions to patients requiring pain and stress services, reconstructive surgery or services in rehabilitation medicine, psychiatric services, substance abuse services, and services for the terminally ill.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-432. Hospital physical plant
Special hospitals shall comply with the requirements of R9-10-232 with the following additions and exceptions:

1. New construction in special hospitals which limit admissions to patients requiring psychiatric services may, notwithstanding the provisions in the standards adopted by reference in R9-1-412(A) and R9-1-412(B), have exit corridors of a minimum width of 6 feet (1.82 meters) in lieu of 8 feet (2.43 meters) if alcoves opening onto the corridors are provided. The alcoves, suitable for temporary parking of linen carts, food carts, cleaning carts, and other equipment, shall have a minimum of 20 square feet (1.85 square meters) and be spaced no farther apart than 40 linear feet (12.2 meters) of corridor length or fraction thereof. New construction in these special hospitals shall conform to the requirements listed in the chapter for Long-Term Care of the standard adopted by reference in R9-1-412(F) except that:
   a. The examination and treatment room may be omitted.
   b. Parking space for stretchers and wheelchairs may be omitted.
   c. Combined inpatient dining and recreation areas shall be increased to 40 square feet (3.71 square meters) per bed, for the first 100 beds and 30 square feet (2.78 square meters) for all beds in excess of 100.
   d. In addition to inpatient's dining and recreation space an additional 40 square feet (3.71 square meters) shall be provided for each day care patient if a day care program is provided.
   e. The nurse call system may be omitted.
   f. Physical therapy facilities may be omitted.
   g. General storage rooms may be reduced in size to 5 square feet (.46 square meters) per bed.
   h. Seclusion rooms, i.e., those rooms not assigned as patient rooms and used only as holding rooms, will not be counted as licensed beds.
   i. Hospital type elevators may be omitted.
   j. Doors to patient rooms may be a minimum of 3 feet (91 centimeters) clear width.
   k. Bed pan washers are not required in patient bath rooms.
   l. Toilet training rooms may be omitted.
   m. Emergency generators may be omitted; however, emergency power to provide lighting to means of egress and exit signs and power to alarm systems, smoke detection systems, sprinkler alarm systems, and magnetic hold-open devices on doors shall be provided.
2. New construction for special hospitals limiting admissions to terminally ill patients shall conform to the requirements listed in the chapter for Long-Term Care of the standard adopted by reference in R9-1-412(F), except that:
   a. An examination room is not required.
   b. In addition to inpatient's dining and recreation space an additional 40 square feet (3.71 square meters) shall be provided for each day care patient if a day care program is provided.
   c. If a personal care room (beauty parlor or barber shop) is not provided within the facility, provision shall be made for outside services.
   d. An attractive outdoor recreation area, suitable for lounging shall be provided.
   e. A room suitable for storing and dispensing all necessary patient medication shall be provided.
   f. In the event the facility for terminally ill patients is a separately licensed component of a general hospital, separate dining and recreational spaces shall be provided.
3. New construction for special hospitals limiting admissions to patients requiring treatment of pain and stress shall conform to the requirements listed in the chapter for Hospitals of the standard adopted by reference in R9-1-412(F), except that:
   a. Rooms for disturbed patients are not required.
   b. Psychiatric nursing units are not required.
   c. Surgical facilities are not required within the facility.

d. Radiology facilities are not required within the facility.
e. Laboratory facilities are not required within the facility.
f. A group therapy room or rooms shall be provided at a rate of 50 square feet (4.6 square meters) per patient.
g. Hospital type elevators may be omitted.
h. Doors to patients' rooms may be a minimum of 3 feet (91 centimeters) clear width.
i. Bed pan washers are not required in patient bath rooms.
j. Toilet training rooms may be omitted.
k. Emergency generators may be omitted; however, emergency power to provide lighting to means of egress and exit signs, and power to alarm systems, smoke detection systems, sprinkler alarm systems, and magnetic hold-open devices on doors shall be provided.
l. Nurse call systems may be omitted.
m. The width of exit access corridors may be a minimum of 6 feet (1.82 meters) in lieu of 8 feet (2.43 meters) if alcoves opening onto the corridors are provided. The alcoves, suitable for temporary parking of linen carts, food carts, cleaning carts, and other equipment, shall have a minimum of 20 square feet (1.85 square meters) and be spaced no farther apart than 40 linear feet (12.2 meters) of corridor length or fraction thereof.

4. New construction for special hospitals limiting admissions to patients requiring treatment for substance abuse shall conform to the requirements listed in the chapter for Long-Term Care of the standard adopted by reference in R9-1-412(F), except that:
a. Physical therapy and occupational therapy facilities are not required.
b. Parking space for stretchers and wheelchairs may be omitted.
c. Hospital type elevators may be omitted.
d. Door to patients' rooms may be a minimum of 3 feet (91 centimeters) clear width.
e. Bed pan washers are not required in patient bath rooms.
f. Toilet training rooms may be omitted.
g. Emergency generators may be omitted; however, emergency power to lighting to means of egress, exit signs, and power to alarm systems, smoke detection systems, sprinkler alarm systems, and magnetic hold-open devices on doors shall be provided.
h. General storage rooms may be reduced in size to 5 square feet (.46 square meters) per bed.
i. The width of exit access corridors may be a minimum of 6 feet (1.82 meters) in lieu of 8 feet (2.43 meters) if alcoves opening onto the corridors are provided. The alcoves, suitable for temporary parking of linen carts, food carts, cleaning carts, and other equipment, shall have a minimum of 20 square feet (1.85 square meters) and be spaced no farther apart than 40 linear feet (12.2 meters) of corridor length or fraction thereof.
j. Nurse call systems may be omitted.

5. New construction for special hospitals limiting admissions to patients requiring reconstructive surgery or services in rehabilitation medicine shall conform to the requirements listed in the chapter for Hospitals of the standard adopted by reference in R9-1-412(F), except that:
a. Patient rooms exclusively for the use of the pediatric patient may have a maximum capacity of eight patients for no more than 50 percent of the total pediatric beds.
b. Pediatric patient rooms with more than 4 beds shall contain a nursing desk positioned to allow the staff constant visual observation of the patients.
c. In addition, all patient toilet rooms shall be designed in accordance with provisions for the handicapped person as required by the standard adopted by reference in R9-1-412(I); however, toilet heights shall be established as required by the service offered and type of patient served by the hospital.
d. The number of parking spaces designed in accordance with provisions for the handicapped person as required by the standard adopted by reference in R9-1-412(I) shall be provided for new construction at a rate of 1 space per 10 beds; however, based on the services offered, the Hospital may be excused from the above handicapped parking space requirement with prior approval from the Department.

6. Special hospitals limiting admissions to patients requiring treatment for obstetrical and gynecological services may exceed the maximum patient room square footage for patient rooms when used as birthing rooms for labor, delivery, and postpartum care by adding additional space usually allotted to bassinet space in the nursery.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-433. Rates and charges
Special hospitals shall comply with the requirements of R9-10-233.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-434. License application
Application for licensure for special hospitals shall include a statement describing the type of services the hospital will offer.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-435. Special hospitals that limit admission to patients requiring pain and stress services
There shall be written policies and procedures concerning the provision of special treatments such as:
1. Drug therapy.
2. Biofeedback and autogenic training.
3. Transcutaneous and neural stimulation.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-436. Special hospitals that limit admissions to patients requiring psychiatric services
A. Psychological services
1. Psychological services shall be available to meet the needs of patients.
2. There shall be a written plan describing the organization of psychology services or arrangements for provisions for such services.
3. There shall be sufficient number of appropriately qualified staff to provide psychological services.
4. The psychology staff shall participate in development of the treatment plan for each patient.

5. There shall be documentation of psychological services provided.
6. There shall be written procedures for the referral of patients for evaluation and treatment not available in the hospital.

B. Social services
1. There shall be adequate staff to meet the specific needs of individual patients and their families.
2. There shall be a written plan describing the organization of social services.
3. Social work services shall be under the supervision of a qualified social worker.

C. Patient activities program
1. There shall be adequate, suitable area available for patient activities including a patient lounge.
2. There shall be a written patient activities plan suitable to the needs of each patient. Activities shall encourage independence and self-care consistent with patient's condition.
3. Patient activities shall be supervised by a patient's activity director or an employee of the hospital who shall receive consultation from a qualified consultant. Records shall be maintained of patient attendance, services rendered, patient's response, and recommendations made by the consultant.
4. A schedule of patient activities shall be posted in a prominent place in an area of the hospital readily available to all patients.
5. Activities shall be available to bedfast patients.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-437. Special hospitals limiting admissions to patients requiring services in rehabilitation medicine

A. Organization. Rehabilitation services shall be under the medical direction of a physician specializing in rehabilitation medicine.

B. Services. In addition to physical therapy, occupational therapy, speech therapy, and audiology services as required by R9-10-224(A), prosthetic and orthotic, psychology, vocational and social services shall be available.

C. Facilities, supplies, equipment. There shall be:
1. Adequate facilities available for the provision of therapy, including suitable space and equipment, for teaching activities of daily living.
2. Physical and occupational therapy areas that include a reception area, treatment area, office space for therapy staff, storage space for supplies and equipment, and adequate appropriate equipment as determined by professional staff to meet the requirements for treatment of patients.
3. Suitable space and equipment for speech therapy, sensory testing and evaluation within the facility or through arrangements with an existing community facility.
4. Adequate office space for patient vocational counseling and evaluation.
5. Adequate space shall be provided for fitting and adjustment of prosthetic and orthotic devices.

D. Outpatient services. When outpatient services are offered, the equipment shall be adequate to provide safe, prompt services to the number and types of patients served.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-438. Special hospitals limiting admissions to patients requiring substance abuse services

A. Services. The following shall be available:
1. Detoxification.
2. Substance abuse rehabilitation.
   a. Substance abuse rehabilitation service which includes physical, psychological, education and socio-cultural aspects of rehabilitation.
   b. Social and recreational activities suited to the needs of the patients shall be available.
   c. Patients may participate in facility tasks, household chores, and general duties when these are included in the plan of treatment.
3. Outpatient services shall be provided in the hospital or by written agreement for outside services.
4. Family services. Counseling and information services shall be available to families of patients.

B. Staffing
1. There shall be sufficient staff to assure the safety and welfare of the patients, and to achieve the objectives of the program.
2. The substance abuse rehabilitation program in hospitals treating alcoholism shall be staffed by qualified persons at a rate of not less than 1 per 10 patients undergoing alcoholism treatment.
3. Psychologists, social workers, and physical therapists shall be available as required to meet the needs of patients.

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).

R9-10-439. Repealed

Historical Note
Adopted effective January 28, 1980 (Supp. 80-1).
Repealed effective October 30, 1989 (Supp. 89-4).

ARTICLE 5. ADULT DAY HEALTH CARE FACILITIES

R9-10-501. Definitions

In this Article, unless the context otherwise requires:
1. "Abuse" means the same as defined in A.R.S. § 46-451(A)(1).
2. "Activities of daily living" means ambulating, bathing, toileting, shaving, brushing teeth, combing hair, dressing, and eating.
3. "Advance directives" means a living will, prehospital medical care directive, or a health care power of attorney.
4. "Caregiver" means an adult who provides functionally impaired adults with supervision and assistance in the preparation of meals, housework, and personal grooming.
5. "Care Plan" means a written program of action for each participant's care based upon an assessment of that person's physical, nutritional, psychosocial, economic, environmental strengths and needs and implemented pursuant to established short- and long-term goals.
6. "Communicable disease" means the same as defined in A.R.S. § 36-661(4).
7. "Licensed nurse" means a nurse licensed pursuant to A.R.S. Title 32, Chapter 15.
8. "Medical provider" means a physician licensed pursuant to A.R.S. Title 32, Chapters 13 and 17, a physician's assistant licensed pursuant to A.R.S. Title 32, Chapter 25, or a nurse practitioner licensed pursuant to A.R.S. Title 32, Chapter 15.
9. "Medication" means a drug, prescription or nonprescription, administered to or self-administered by a participant

to maintain health or to prevent or treat an illness or disease.

10. "Participant" means a person enrolled in an adult day health care facility.
11. "Participant's representative" means a person acting on behalf of a participant, under the written consent of the participant or the participant's legal guardian.
12. "Personal living skills training" means teaching a participant techniques in order to maintain or improve the participant's independence in performing activities of daily living.
13. "Personnel" means all staff, including employees and volunteers, who perform services for an adult day health care facility and have direct or indirect contact with the participants at the facility.
14. "Physical restraint" means confinement in a locked room or the use of any article, device, or garment which interferes with freedom of movement that cannot be easily removed by the participant and is used to control the participant's mobility.
15. "Significant change in condition" means a life-threatening or clinical complication.
16. "Volunteer" means a person who provides services at an adult day health care facility without compensation.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency expired. Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2).

R9-10-502. Administration

A. The governing authority shall consist of 1 or more persons responsible for organizing and managing the facility, establishing policies and procedures, establishing facility rules, and ensuring compliance with state laws, rules, and local ordinances.

B. The governing authority shall appoint an administrator who shall have the authority and responsibility to operate the facility. The Administrator shall:
1. Be 21 years of age or older;
2. Remain on the premises, or ensure that a designee is present, whenever participants are present in the facility; and
3. Designate, in writing, a staff person who is 21 years of age or older to act as administrator when the administrator is absent.

C. The administrator shall be responsible for:
1. Managing adult day health services;
2. Staffing and conducting employee orientation;
3. In-service training;
4. Recordkeeping;
5. Supervising and evaluating staff performance;
6. Ensuring that participants receive services which are offered by the facility and specified in the participants' care plan;
7. Ensuring that a monthly calendar of planned activities is posted and that materials, supplies, and equipment are provided for the activities which are clean, safe, and in working condition;
8. Assisting in the formation of a participants' council pursuant to R9-10-506 and maintaining communication with the council;
9. Ensuring that facility rules are followed and assisting participants in exercising their rights pursuant to R9-10-505;
10. Ensuring that all participants in the facility annually provide the same type of evidence of being free from pulmonary tuberculosis as required of personnel in R9-10-503(A); and
11. Maintaining the following documents and references in the facility;
    a. Operating licenses and permits,
    b. Schedules of rates and charges,
    c. Policies and procedures,
    d. Monthly activity calendars for the preceding 90 days,
    e. Menus for the preceding 60 days,
    f. Incident reports,
    g. Current fire and sanitation reports,
    h. Records of fire and disaster drills,
    i. Orientation and in-service program records,
    j. Personnel records, and
    k. Participant records.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2).

R9-10-503. Personnel

A. Personnel, prior to being employed and annually thereafter, shall submit 1 of the following as evidence of freedom from pulmonary tuberculosis:
1. A report of a negative Mantoux skin test taken within six months of submitting the report; or
2. A written statement from a medical provider stating that, upon an evaluation of a positive Mantoux skin test taken within six months of submitting the medical provider's statement or a history of a positive Mantoux skin test, the individual was found to be free from tuberculosis.

B. All personnel shall meet the following requirements:
1. Be 18 years of age or older.
2. Not be a participant of the facility as defined in R9-10-501(10).
3. Within the first week of employment, attend orientation that includes:
    a. Policies and procedures, including personnel procedures;
    b. Participant rights and facility rules;
    c. Protection of participant privacy and confidentiality;

d. Basic infection control techniques, including hand washing and prevention of communicable diseases; and
e. Fire, safety, and emergency procedures.

4. Attend ten hours of in-service training per year which may include time spent in orientation.

C. Personnel providing direct care to participants shall attend four or more hours of orientation, in addition to complying with paragraph (B)(3), before providing care to participants. The orientation shall include:
1. Communication skills,
2. Assistance with the activities of daily living,
3. Personal living skills training, and
4. Special needs of the elderly and functionally impaired.

D. The administrator shall maintain personnel records which include:
1. Application for employment,
2. Verification of training and certification,
3. Initial proof of freedom from tuberculosis and annual verification statement thereafter, and
4. Orientation and in-service training records that include:
   a. Class content,
   b. Instructor's name, and
   c. Signatures and job titles of those who attend.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2).

R9-10-504. Staffing

A. The administrator shall ensure that staffing provides:
1. Adult day health services,
2. Nutritional services,
3. Activities program,
4. Social services,
5. Housekeeping services, and
6. Safety program.

B. The administrator shall ensure that two staff members are on duty at all times when two or more participants are in the facility. One staff member, certified in cardiopulmonary resuscitation and first-aid training, shall be on duty at all times.

C. A registered nurse shall supervise health care needs of participants.

D. A licensed nurse shall be on duty daily to perform the following functions:
1. Administer medications and treatments,
2. Monitor participant's health status, and
3. Conduct initial health assessments.

E. Each facility which is operated by a nursing care institution shall not share staff with the nursing care institution during the course of a day.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 198, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2).

R9-10-505. Participant Rights

A. The administrator shall establish and implement a written policy regarding participant rights and facility rules.

B. The administrator shall give each participant or participant's representative a list of participant rights and a copy of facility rules at the time of enrollment. The receipt of the documents shall be acknowledged in writing.

C. The administrator shall post the participant rights and facility rules in a conspicuous area.

D. The administrator and staff shall ensure that language barriers or physical handicaps do not prevent each participant or participant's representative from becoming aware of participant rights.

E. A participant shall have the following rights:
1. To be treated with consideration, respect, and full recognition of the dignity and individuality of each participant;
2. To be free from the following:
   a. Medical, psychological, physical, and chemical abuse;
   b. Physical restraints; and
   c. Use of psychoactive drugs administered for the purposes of discipline or convenience and not required to treat the participant's medical symptoms;
3. To refuse treatment or withdraw consent for treatment;
4. To participate in the development of and receive the services specified in the care plan.
5. To have medical and financial records kept in confidence. The release of such records shall be by written consent of the participant or participant's representative, except as otherwise required or permitted by law;
6. To inspect the participant's own records at a time agreed upon by the participant and the facility;
7. To be informed of the following:
   a. Rates and charges for the use of the facilities, and
   b. The process for contacting the local office of adult protective services;
8. To communicate, associate, and meet privately with persons of the participant's choice;
9. To have access to a telephone, to make and receive calls, and to send and receive correspondence without interception or interference by the facility;
10. To arrive and depart from the facility freely, consistent with the participant's care plan and personal safety; and
11. To exercise other civil rights and religious liberties, including the right to make personal decisions and to submit grievances without retaliation.

Historical Note

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R9-10-506. Participants' Council

A. The participants' council shall:
1. Be composed of participants who are willing to serve on the council and take part in scheduled meetings,
2. Develop guidelines that govern the council's activities,
3. Meet quarterly and record minutes of the meeting, and
4. Provide written input to the facility staff on planned activities and facility policies.

B. The participants' council may invite facility staff or the administrator to attend their meetings.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2).

R9-10-507. Enrollment

A. Prior to enrollment, and annually thereafter, the administrator shall ensure that each participant provides to the facility the same type of evidence of being free from pulmonary tuberculosis as required of personnel in R9-10-503(A).

B. The administrator shall enroll a participant in the facility upon written agreement between the participant or the participant's representative and the facility. The agreement shall include:
1. Enrollment requirements,
2. Statement of the customary services that the facility provides,
3. Statement of services that are available at an additional cost.
4. Statement of all fees and charges,
5. Procedures for termination of an enrollment agreement,
6. Copy of participant rights and facility rules,
7. Persons to be notified in the event of an emergency, and
8. Copy of facility procedure on advanced directives.

C. The administrator shall give 1 copy of the enrollment agreement to the participant or participant's representative and keep the original in the participant's record.

D. The administrator shall ensure that each participant enrolled in the facility shall have a signed written medical assessment completed by the participant's medical provider within 60 days prior to enrollment. The assessment shall include:
1. Information that addresses the participant's health and mental status and cognitive impairments;
2. Physical, mental, and emotional problems including medications, treatments, special dietary needs, and allergies; and
3. Evidence of freedom from communicable diseases.

E. At the time of enrollment, the participant or participant's representative, in consultation with the administrator, shall determine if the participant is capable of signing in and out of the facility. This determination shall be documented in the participant's record.

F. The administrator shall ensure that a comprehensive written assessment of the participant is completed by the participant's tenth visit or within 30 calendar days of enrollment, whichever comes first. The assessment shall include the participant's:
1. Physical health,
2. Mental and emotional status,
3. Social history,
4. Medical provider orders,
5. Adult day health services to be provided, and
6. Emergency information that includes the following:
   a. Name and telephone number of participant's medical provider;
   b. Hospital choice;
   c. Participant's representative, family member, or care giver; and
   d. Any advance directives.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2).

R9-10-508. Discharge

A. The administrator may terminate an enrollment agreement after giving the participant or participant's representative a five-day written notice for any of the following reasons:
1. Evidence of repeated failure to abide by the facility's rules,
2. Documented proof of failure to pay,
3. Behavior which is dangerous to self or which interferes with the physical or psychological well-being of other residents, or
4. Participant's service requirements exceed those services for which the facility is licensed to provide.

B. The administrator shall ensure that a discharge plan is included in the care plan when the discharge is anticipated and shall include recommendations for continuing care and referrals to community service agencies.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2).

R9-10-509. Adult Day Health Services

A. The staff shall be responsible for the supervision of the participants except for the periods of the day the participant signs out or is signed out according to the facility's policies and procedures.

B. Staff shall provide assistance with activities of daily living and supervision of personal hygiene in accordance with the participant's care plan. Where bathing is required in the care plan, only trained staff shall provide the assistance in bathing.

C. Staff shall provide planned therapeutic individual and group activities in accordance with the participant's care plan. The activities shall include:
1. Physical activities,
2. Group discussion,
3. Personal living skills training,
4. Reality orientation,
5. Activity daily living skills,
6. Participants' council meetings, and
7. Leisure time.

D. The administrator shall ensure that each participant's health status is monitored by a licensed nurse as follows:
1. Observe changes in a participant's mental and physical condition, including monthly monitoring of participant's vital signs and nutritional status;
2. Document changes in the participant's record; and
3. Report changes to each participant's medical provider or representative.

E. The administrator shall ensure that medications are ordered, administered, stored, and destroyed as follows:
1. The participant's medical provider shall order, in writing, all medications and treatments. The orders shall include the name of the medication or treatment, method of administration, dosage, and frequency.
2. A licensed nurse, medical provider, or an individual as provided by law shall administer medications which cannot be self-administered.
3. A licensed nurse, family member, or an individual as provided by law may prepare patient medication organizers 1 month in advance for self-administration by participants.
4. Staff may remind and supervise a participant who is functionally capable in the self-administration of medication according to the order of the medical provider and instruction of the pharmacist as indicated on the label of the individual container of medication. Supervision may include:
   a. Opening a bottle cap for a participant,
   b. Reading the medication label to the participant,
   c. Checking the self-administration dosage against the label of the container and reassuring the participant that the dosage is correct, and
   d. Observing the participant while the medication is taken.
5. Medications shall be stored as follows:
   a. A locked, secured area shall be provided which may be used for storage of medicines and solutions. This area shall be locked when not in use.
   b. All medications, with the exception of patient medication organizers, shall be stored in their original labeled containers.
   c. Medications requiring refrigeration shall be kept in a separate locked container within the refrigerator.
   d. Medications for external use shall be stored separately from medications for internal use.
6. All expired or discontinued medications, including those of deceased participants, shall be disposed of according to the facility's policies and procedures.
7. An updated drug reference source shall be available for use by staff.

F. The administrator shall ensure that injuries from an accident or incident that affect the participant's health status are reported, investigated, and documented as follows:
1. Participant's medical provider and representative shall be notified immediately of the injuries.
2. Injuries shall be reported to Adult Protective Services pursuant to A.R.S. § 46-454, when applicable.
3. A written accident or incident report shall be prepared on the day of occurrence or when any injury of unknown origin is detected. The report shall include:
   a. Name of the participant,
   b. Date and time of the accident or incident,
   c. Type of accident or incident,
   d. Injury sustained,
   e. Names of witnesses, and
   f. Action taken by the facility.
4. The accident or incident shall be investigated within 24 hours and any corrective action documented on the report form which shall be retained by the facility for 1 year.

G. The administrator shall designate a food service supervisor who shall be responsible for nutrition services that provide for the following:
1. The menu pattern for each meal shall consist of:
   a. Two servings of whole grain or enriched cereals and bread. A serving size is 1 slice of bread, 1/2 to 1 cup of cereal or 1/2 cup enriched grain products.
   b. One serving of vegetables. A serving size is 1/2 (4 ounces) to 1 cup (8 ounces) of all juices and vegetables.
   c. One serving of fruits. A serving size is 1/2 (4 ounces) to 1 cup (8 ounces) of all juices and fruits.
   d. One serving of milk, yogurt, or cheese. A serving size is 1 cup of milk or yogurt, 1 1/2 ounces of cheese, or 3/4 cup (6 ounces) of cottage cheese. Cheese is considered both a dairy product and a protein and can be counted as one or the other but not both.
   e. One serving of protein: meat, fish, poultry, cheese, egg, peanut butter, peas, beans, lentils, or equivalent. One serving size is 2 to 3 ounces of lean meat without bone, 1 cup dry beans or legumes, 4 tablespoons or peanut butter, or 2 eggs.
2. Two snacks a day shall be offered to participants. Snacks shall consist of a serving of each of two of the food groups listed in paragraph (E)(1).
3. Meals, including therapeutic meals, shall be served in accordance with preplanned menus that are prepared 1 week in advance and posted in an area accessible to participants.
4. Substitutes of equal nutritional value and complementary to the remainder of the meal may be made as long as substitutes are recorded on the menus.
5. If a participant requires a therapeutic diet, the administrator shall ensure that the diet shall be prescribed in writing by the participant's medical provider.
6. An updated therapeutic diet reference manual shall be available for use by staff, if the facility provides therapeutic diets.
7. Self-help devices that include plate guards, rocking forks, and assistive hand devices shall be available to participants who need them.
8. On-site or catered food preparation, storage, and handling shall comply with applicable food and drink regulations of A.A.C. Title 9, Chapter 8, Article 1.

H. The administrator shall ensure that social services as specified in the participant's care plan are provided to each participant. The services shall include the following:
1. Counseling of an individual or group basis according to the needs of the participant and the person's family, and
2. Referral to therapeutic counseling services, if such services are not available at the facility.

Historical Note
Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2).

R9-10-510. Care Plan

A. An interdisciplinary team shall develop a care plan within seven days after the completion of the comprehensive assessment prepared in accordance with R9-10-507(F). The team shall be comprised of:
1. The participant or participant's representative,
2. Representatives of staff, and
3. Service providers.

B. The interdisciplinary team shall base the care plan on the participant's comprehensive assessment. The care plan shall include:
1. Medical or health problems, including physical, mental, and emotional disabilities or impairments;
2. Adult day health services to be provided;
3. Goals and objectives of care that are time limited and measurable;
4. Interventions required to achieve objectives, including recommendations for therapy and referrals to other service providers;
5. Any advance directives; and
6. Discharge plan pursuant to R9-10-508(B).

C. The interdisciplinary team shall review and update a participant's care plan every six months or earlier when there is a significant change in the participant's condition.

Historical Note
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R9-10-511. Participant Records

A. The administrator shall ensure that up-to-date participant records are available to the participant or participant's representative upon 48 hours' written notice to the facility, excluding weekends and holidays.

B. Records for each participant shall include the following:
1. Full name, date of birth, social security number, and address;
2. Names, addresses, telephone numbers of participant's representative, medical provider, and other medical and nonmedical providers involved in the care of the participant;
3. Enrollment agreement;
4. Emergency information;
5. Written acknowledgment of the receipt of copies of participant rights and facility rules;
6. Signed medical provider's assessment;
7. Medical provider's orders;
8. Evidence of freedom from tuberculosis;
9. Comprehensive assessment;
10. Records of medical care and medications provided by the facility;
11. Vital signs and nutritional status;
12. Care plan;
13. Documentation of any significant changes in participant behavior or condition, including injuries and accidents, and notification of the participant's medical provider and participant's representative;
14. Signed authorization if medical information is released;
15. Determination of participant's capability of signing in or out of the facility; and
16. Discharge date, if applicable.

C. Records shall be legibly recorded in ink. Each entry shall be dated and signed. Records shall be protected at all times from possible loss, damage, or unauthorized use.

D. Records shall be retained for three years.

E. If the facility ceases operation, copies of records shall be available upon the request of the participant or participant's representative for three years from the date of closure.

Historical Note
Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2).

R9-10-512. Physical Plant Requirements

A. Existing facilities licensed prior to the adoption of these rules shall conform to the requirements of A.A.C. R9-1-412(B), Life Safety Code, Chapter 11, "Existing Educational Occupancies".

B. Facilities licensed after the effective date of these rules shall conform to the requirements applicable to educational occupancies in the codes adopted by reference in A.A.C. R9-1-412, excluding A.A.C. R9-1-412(B), Life Safety Code, Chapter 11, "Existing Educational Occupancies".

C. The facility shall have space to accommodate adult day health services including:
1. Individual and group activities;
2. Special therapies, if provided;

3. Storage areas for program and operating supplies; and
4. A quiet rest area for participants.

D. If the facility is operated by a nursing care institution, the facility shall be physically and functionally separate from the nursing care institution.

E. If any portion of a building is used for purposes other than adult day health care, that portion of the building which participants regularly occupy shall be used only for adult day health care purposes during operational hours.

F. There shall be 40 square feet or more of indoor activity space for each participant. Floor space of bathrooms, halls, storage areas, kitchens, wall thicknesses, and rooms designated for staff use shall be excluded when computing the minimum activity space.

G. An outside activity space shall be provided which:
1. Is accessible to the building without crossing thorough fares,
2, Is free from hazards,
3. Has a hard-surfaced section for wheelchairs, and
4. Has an available shaded area.

H. The facility temperature shall be maintained at a range from 68° to 82° F.

I. All stairs used by participants shall:
1. Be edge-marked with high contrast color,
2. Be slip resistant, and
3. Have a tactile warning at the top of the stair run.

J. Each facility shall have bathrooms with 1 toilet and a sink for each ten participants. Bathrooms shall also have toilet and bathroom fixtures, towel bars, towel and soap dispensers, and mirrors accessible and usable for all participants.

K. If bathing facilities are provided, all tub and shower floors shall have slip-resistant surfaces.

L. Dining areas shall be furnished with dining tables and chairs and large enough to accommodate all participants.

M. There shall be a physical separation of dining facilities from food preparation areas.

N. There shall be food preparation, storage, and handling areas in facilities serving food. These areas shall not be used as a passageway by participants.

O. All flooring shall be slip-resistant.

P. All swimming pools shall, unless otherwise required in A.R.S. § 36-1681:
1. Be enclosed by a five-foot solid wall or a five-foot fence with openings not exceeding six inches, and
2. Have 1 or more self-closing and self-latching gates which shall be locked when the pool is not in use.

Q. Swimming pools which are used by participants shall:
1. Conform to the minimum requirements for semipublic pools as set forth in state and local rules for design, construction, and operation of public and semipublic swimming pools;
2. Have posted pool safety rules; and
3. Be supervised when in use.

Historical Note
Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2).

R9-10-513. Environmental Standards

A. The facility shall be maintained free from offensive odors, hazards, insects, rodents, and accumulations of dirt, garbage, and other refuse.

B. Combustible liquids, hazardous materials, and house and garden insecticides shall be safely stored in their original labeled containers, outside of the facility, in a locked area inaccessible to participants.

C. All windows and doors opening to the outside shall be screened if they are kept open at any time for ventilation or other purposes.

D. The use of a common drinking utensil is prohibited. When paper cups are used, clean single-use cups are required.

E. If laundry facilities are provided on the premises, soiled and clean laundry areas shall be separately maintained.

F. There shall be no pets allowed in treatment, food storage, food preparation, and dining areas.

Historical Note
Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2).

R9-10-514. Safety Standards

A. The administrator shall develop a written plan of operation with procedures to be followed in the event of fire, disaster, or threat to participant's safety. The plan shall include:
1. Telephone numbers for contacting local emergency medical, fire, and other service agencies;
2. The route to be used when evacuating participants; and
3. Designation of the specific places to which participants will be evacuated.

B. The administrator shall ensure that each participant receives orientation to the facility's exits within two visits of the person's enrollment. This orientation shall be documented in the participant's record.

C. A current floor plan shall be posted in a central location on each floor and shall include an emergency exit plan.

D. A fire evacuation drill shall be conducted once every three months.

E. A disaster drill shall be conducted once every six months. Disaster drills may include the involvement of participants.

F. Records of fire and evacuation drills shall be retained for 1 year and include the date, time, length of time for full evacuation, and a critique of the drill.

Historical Note
Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to

A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed, new Section adopted effective April 4, 1994 (Supp. 94-2).

R9-10-515. Repealed

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed effective April 4, 1994 (Supp. 94-2).

R9-10-516. Repealed

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section repealed effective April 4, 1994 (Supp. 94-2).

R9-10-517. Repealed

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4). Section repealed effective April 4, 1994 (Supp. 94-2).

R9-10-518. Repealed

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4). Section repealed effective April 4, 1994 (Supp. 94-2).

Editor's Note: The following Article was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

ARTICLE 6. REPEALED

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-611. Repealed

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-611 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-612. Repealed

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-612 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-613. Repealed

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-613 repealed effective November 1, 1998,

under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-614. Repealed

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-614 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-615. Repealed

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-615 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-616. Repealed

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-616 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-617. Repealed

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-617 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-618. Repealed

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-618 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-619. Repealed

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-619 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-620. Repealed

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-620 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice

of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-621. Repealed

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Correction, subsection (H), after "... 105°F" added "nor more than 110°F" as certified effective November 6, 1978 (Supp. 87-2). Section R9-10-621 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-622. Repealed

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-622 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-623. Repealed

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-623 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-624. Repealed

Historical Note

Adopted effective November 6, 1978 (Supp. 78-6). Section R9-10-624 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Article was repealed and a new Article adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on these rules (Supp. 98-4).

ARTICLE 7. ASSISTED LIVING FACILITIES

Editor's Note: The following Section was repealed and a new Article adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on these rules (Supp. 98-4).

R9-10-701. Definitions

The following definitions apply in this Article unless otherwise specified:

1. "Abuse" means the intentional infliction of physical harm; injury caused by negligent acts or omissions; unreasonable confinement; sexual abuse or sexual assault; or a pattern of ridiculing or demeaning a resident, making derogatory remarks, verbally harassing, or threatening to inflict physical harm on a resident.
2. "Accept" or "acceptance" means:
   a. An individual begins living in and receiving services at an assisted living facility; or
   b. An individual begins receiving adult day health care services or respite care services from an assisted living facility.
3. "Accident" means an unexpected occurrence that causes harm to a resident.
4. "Activities of daily living" means bathing, dressing, grooming, eating, mobility, transfer, and toileting.
5. *"Adult day health care services" means a program that provides planned care supervision and activities, personal care, personal living skills training, meals and health monitoring in a group setting during a portion of a continuous twenty-four hour period. Adult day health services may also include preventive, therapeutic and restorative health related services that do not include behavioral health services.*
6. *"Adult foster care" means a residential setting which provides room and board and adult foster care services for at least one and no more than four adults who are participants in the Arizona long-term care system pursuant to Chapter 29, Article 2 of this title and in which the sponsor or the manager resides with the residents and integrates the residents who are receiving adult foster care into that person's family.*
7. "Applicant" means an individual, firm, partnership, association, or corporation that has submitted an application for:
   a. An assisted living facility license;
   b. Department approval of an exemption in R9-10-702; or
   c. Department approval of an assisted living training program.

8. "Assessment" means a written analysis of a resident's abilities; preferences; and need for supervisory care services, personal care services, or directed care services.
9. "Assistance" means the help or aid necessary to complete a function or a task.
10. "Assistant caregiver" means an individual who assists in providing supervisory care services, personal care services, or directed care services under the direct supervision of a manager or caregiver.
11. *"Assisted living center" or "center" means an assisted living facility that provides resident rooms or residential units to eleven or more residents.*
12. *"Assisted living facility" means a residential care institution, including adult foster care, that provides or contracts to provide supervisory care services, personal care services or directed care services on a continuing basis.*
13. *"Assisted living home" or "home" means an assisted living facility that provides resident rooms to ten or fewer residents.*
14. "Bathing" means washing, rinsing, and drying all parts of an individual's body.
15. "Bedbound" means confined to a bed or chair because of an inability to ambulate even with assistance.
16. "Bedroom" or "room" means a portion of a facility that is wall-enclosed with a door where a resident sleeps and maintains personal items.
17. "Behavioral health residential services" means a therapeutic regimen of screening, evaluation, treatment, or rehabilitation provided on a 24-hour basis to individuals suffering from mental disorders, emotional conditions, or the effects of substance abuse.
18. "Board of Examiners" means the Board of Examiners of Nursing Care Institution Administrators and Assisted Living Facility Managers.
19. "Caregiver" means an individual who provides supervisory care services, personal care services, or directed care services to residents.
20. "Charge" means a 1-time payment or a payment that is not incurred in fixed, regular intervals.
21. "Chemical restraint" means any medication that is administered for purposes of discipline or convenience and is not required to treat a resident's medical symptoms.
22. "Clean" means free of dirt or debris by such methods as washing with soap and water, vacuuming, wiping, dusting, or sweeping.
23. "Common areas" means portions of a facility or facility grounds accessible to residents.
24. "Communicable disease" means the same as defined in A.A.C. R9-6-101.
25. "Conspicuously posted" means placed at a location within a facility that is accessible and visible to residents and the public.
26. "Continuous" means available at all times without cessation, break, or interruption.
27. "CPR" means cardiopulmonary resuscitation.
28. "Current" means up-to-date, extending to the present time.
29. "Day" means calendar day.
30. *"Department" means the department of health services.*
31. "Deposit" means monies or property given to a licensee to assure payment or performance.
32. "D.E.S." means the Arizona Department of Economic Security.
33. "Directed care services" means programs and services, including personal care services, provided to persons who are incapable of recognizing danger, summoning assistance, expressing need or making basic care decisions.
34. "Direction" means authoritative policy or procedural guidance for the accomplishment of a function or activity.
35. "Direct self-care" means a resident is able to recognize danger, summon assistance, express need, and make basic care decisions.
36. "Direct supervision" means the physical presence of a manager or caregiver providing direction to an assistant caregiver or volunteer in a facility or during an activity outside the facility.
37. "Documentation" means written supportive information.
38. "Door" means a movable hard-surfaced barrier for opening or closing an entranceway that swings on hinges or slides in groves and is capable of being closed for privacy and fire safety.
39. "Dressing" means choosing, putting on, securing fasteners, and removing clothing, footwear, artificial limbs, braces, and other appliances including those appropriate for current weather conditions.
40. "Eating" means putting food and fluids into the digestive system.
41. "Employee" means a licensee, manager, caregiver, or assistant caregiver who provides or assists in the provision of supervisory care services, personal care services, or directed care services to residents.
42. "Exploitation" means the illegal use of a resident's resources for another's profit or advantage according to A.R.S. Title 46, Chapter 4, or A.R.S. Title 13, Chapter 18, 19, 20, or 21.
43. *"Facility" or "facilities" means buildings used by a health care institution for providing any types of services as defined in this chapter.*
44. "Facility grounds" means the outdoor area, adjacent to the facility, designated by an applicant or licensee for use by residents.
45. "Fees" means payments in fixed, regular intervals.
46. "Food" means any raw, cooked or processed edible substance, ice, beverage or ingredient used or intended for use or for sale, in whole or in part, for human consumption.
47. "Food services" means the storage, preparation, serving, and cleaning up of food intended for consumption in an assisted living facility.
48. "General supervision" means guidance of a resident by an employee as required by the needs of the resident including the following: being aware of a resident's general whereabouts, monitoring the activities of the resident while on the premises to ensure the health, safety, and welfare of the resident; reminding the resident to carry out activities of daily living; and reminding the resident of activities or appointments.
49. "Grooming" means combing or brushing hair, washing face and hands, shaving, caring for nails, oral hygiene including denture care, and menstrual care.
50. "Guardian" means an individual appointed by a court according to A.R.S. Title 14, Chapter 5, Article 3.
51. "Hazard" means a condition or situation where a resident may suffer physical injury.
52. "Health care directive" means the same as defined in A.R.S. § 36-3201.
53. *"Health care institution" means every place, institution, building or agency, whether organized for profit or not, which provides facilities with medical services, nursing services, health screening services, other health-related*

services, supervisory care services, personal care services, directed care services and includes home health agencies as defined in section 36-151 and hospice service agencies.

54. "Health-related experience" means work in a health care institution, the professional fields of nursing, social work, gerontology, or other closely-related field, or providing health or health-related services to 1 or more adults.
55. *"Health-related services" means services, other than medical, pertaining to general supervision, protective, preventive and personal care services, supervisory care services or directed care services.*
56. *"Home health agency" means an agency or organization, or a subdivision of such an agency or organization, which meets all of the following requirements.*
    a. *Is primarily engaged in providing skilled nursing services and other therapeutic services.*
    b. *Has policies, established by a group of professional personnel, associated with the agency or organization, including one or more physicians and one or more registered professional nurses, to govern the services referred to in subdivision (a), which it provides, and provides for supervision of such services by a physician or registered professional nurse.*
    c. *Maintains clinical records on all patients.*
57. *"Hospice service agency" means an agency or organization, or a subdivision of that agency or organization, which is engaged in providing hospice services at the place of residence of its clients.*
58. "Hour" means 60 minutes.
59. "Incident" means an occurrence or event that has the potential to cause harm to a resident.
60. "Independent" means able to complete a function or task without assistance.
61. "Intermittent" means periodically scheduled and predictable.
62. "Internal facility requirements" means guidelines and standards developed by a licensee that govern a resident's use and occupancy of an assisted living facility.
63. "Key" means a mechanical device used for holding or locking.
64. "Laundry service" means the process of cleaning linens and clothing.
65. "Learning objective" means the specific and measurable behavior, knowledge, or skill an individual demonstrates.
66. "Licensee" means the individual, firm or partnership, association, or corporation licensed by the Department to operate an assisted living facility.
67. "Manager" means an individual designated by the licensee to act on the licensee's behalf in the on-site management of the assisted living facility.
68. "Medical practitioner" means any physician, dentist, podiatrist, or other individual licensed and authorized by law to use and prescribe drugs and devices for the treatment of sick and injured human beings, or for the diagnosis or prevention of sickness in human beings in this state or any state, territory, or district of the United States.
69. "Medication" means a prescription medication as defined in A.R.S. § 32-1901 or a nonprescription drug as defined in A.R.S. § 32-1901 used to maintain health or to prevent or treat an illness, injury, or disease.
70. "Medication administration" or "administration of medication" means the application of a medication to its ultimate destination on the body of a resident.
71. "Medication organizer" means a container that is designed to hold doses of medication and is divided according to date or time increments.
72. "Mobility" means the ability to move within a residential environment.
73. "Neglect" means a pattern of conduct, without a resident's or the resident's informed consent as defined in A.R.S. § 46-451, resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating, or other services necessary to maintain minimum physical or mental health.
74. "Nurse" means an individual licensed and in good standing as a registered nurse or a practical nurse as prescribed in A.R.S. Title 32, Chapter 15.
75. "Nurse practitioner" means an individual licensed as a registered nurse practitioner as prescribed in A.R.S. Title 32, Chapter 15.
76. "Nursing services" means those services pertaining to the curative, restorative and preventive aspects of nursing care that are performed at the direction of a physician by or under the supervision of a registered nurse licensed in this state.
77. "Personal care services" means assistance with activities of daily living that can be performed by persons without professional skills or professional training and includes the coordination or provision of intermittent nursing services and the administration of medications and treatments by a nurse who is licensed pursuant to Title 32, Chapter 15 or as otherwise provided by law.
78. "Personnel" means employees, support staff, and volunteers.
79. "Pharmacist" means an individual licensed as prescribed in A.R.S. Title 32, Chapter 18.
80. "Physical restraint" means the confinement of a resident or the use of any article, device, or garment that cannot be removed by a resident, used to restrict movement, and control the resident's behavior.
81. "Physician" means an individual licensed as prescribed in A.R.S. Title 32, Chapter 13 or Chapter 17.
82. "Physician assistant" means an individual licensed as prescribed in A.R.S. Title 32, Chapter 25.
83. "Poisonous or toxic materials" means chemicals such as insecticides, rodenticides, hazardous cleaning agents, and caustic acids.
84. "Potentially hazardous foods" means the same as defined in A.A.C. R9-8-112.
85. "Premises" means a facility, the facility's grounds and each building or grounds on contiguous property used for administering and operating an assisted living facility.
86. "Primary care provider" means a physician, a physician's assistant, or a nurse practitioner who directs a resident's medical care.
87. "Private duty nurse" means a nurse who provides nursing services to a resident that are arranged, paid for, and overseen by the resident, the representative, or the resident's relatives.
88. "PRN" means pro re nata or medication given as needed.
89. "RN" means a registered nurse licensed as prescribed in A.R.S. Title 32, Chapter 15.
90. "Regular basis" means at recurring, fixed, or uniform intervals.
91. "Relative" means a child, parent, sibling, spouse, grandparent, grandchild, uncle, aunt, niece, nephew, or any individual of the same affiliation through marriage or adoption.

92. "Representative" means a resident's guardian or an individual designated in writing by a resident or by the resident's guardian to aid a resident or act on the resident's behalf.
93. "Residency agreement" means a document signed by a resident or the representative and a licensee or the licensee's designee, detailing the terms of residency as agreed upon by the resident or the representative and the licensee.
94. "Resident" means an individual who is not a relative of the licensee and who:
    a. Lives in an assisted living facility and receives supervisory care services, personal care services or directed care services; or
    b. Receives adult day health care services, or respite care services from an assisted living facility.
95. *"Residential unit" or "unit" means a private apartment, unless otherwise requested by a resident, that includes a living and sleeping space, kitchen area, private bathroom, and storage area.*
96. *"Respite care services" means services provided by a licensed health care institution to persons otherwise cared for in foster homes and in private homes to provide an interval of rest or relief of not more than thirty days to operators of foster homes or to family members.*
97. "Secure" means to control, or alert employees of, the egress of a resident from the facility or facility grounds through the use of a method, device, or structure that ensures resident safety.
98. "Service plan" means a written description of a resident's need for supervisory care services, personal care services, or directed care services and the specific services to be provided to the resident.
99. "Short term" means 14 days or less.
100. "Significant change" means an observable deterioration or improvement in a resident's physical, cognitive, behavioral, or functional condition.
101. *"Supervisory care services" means general supervision, including daily awareness of resident functioning and continuing needs, the ability to intervene in a crisis and assistance in the self-administration of prescribed medications.*
102. "Supervision" means direct overseeing and inspection of the act of accomplishing a function or activity.
103. "Support staff" means any individual who receives compensation from a licensee, but who does not provide supervisory care services, personal care services, or directed care services at an assisted living facility.
104. "Swimming pool" means a contained body of water that is 18 inches or more in depth at any point and wider than 8 feet at any point and intended for swimming.
105. "Termination of residency" or "terminate residency" means a resident is no longer receiving services from an assisted living facility.
106. "Therapeutic diet" means foods prescribed by a physician or an individual authorized by law to prescribe foods.
107. "Toileting" means the discharge and disposal of body waste from bowel or bladder.
108. "Training program" means an individual or an organization that has received written approval from the Department to provide training to assisted living facility personnel and to verify that individuals demonstrate specific skills and knowledge in a level of training.
109. "Transfer" means the movement of an individual's body from a surface to another surface.
110. "Treatment" means a specific procedure used for the prevention, cure, or the improvement of a disease, injury, or illness.
111. "Volunteer" means an individual who provides supervisory care services, personal care services, or directed care services to a resident on a regular basis under the direct supervision of a manager or caregiver at all times but does not receive compensation.

Historical Note

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Editor's Note: The following Section was repealed and a new Article adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on these rules (Supp. 98-4).

R9-10-702. Licensing Classifications

A. The Department shall sub-classify an assisted living facility according to facility size as follows:
1. An assisted living facility providing services to 10 or fewer residents is an assisted living home;
2. An assisted living facility providing services to 11 or more residents is an assisted living center; or
3. An assisted living facility that meets the definition of adult foster care in A.R.S. § 36-401 is an adult foster care.

B. An adult foster care shall comply with the requirements for an assisted living home except as provided by statute and this Article.

C. The Department shall license an assisted living facility to provide 1 of the following levels of service:
1. Supervisory care services,
2. Personal care services, or
3. Directed care services.

D. To change an assisted living facility's sub-classification, a licensee shall submit an application for licensure as required by A.R.S. §§ 36-421 and 36-422.

E. To change the level of service an assisted living facility is licensed to provide, a licensee shall submit to the Department a written request for a change in level of service and documentation of the assisted living facility's compliance with requirements in this Article for the requested level of service.
1. Within 60 days from the date of receipt of the request, the Department shall review the requested change and send written notice to the licensee. The Department may conduct an on-site review of the assisted living facility to determine compliance.

a. If an assisted living facility does not comply with this Article and the requirements for the requested level of service, the Department shall provide the licensee with written notice stating the requirements necessary for compliance with this Article and the requirements for the requested level of service.
b. When the assisted living facility complies with the requirements of this Article and the requirements for the requested level of service, the Department shall send the licensee an amended license that incorporates the requested level of service but retains the expiration date of the current license.

2. A licensee shall not provide services at the requested level of service until an amended license is issued.

F. The Department may grant an exception from the requirements in R9-10-716(C)(1)(a), R9-10-720(A)(1), R9-10-720(C)(1)(c), or R9-10-720(C)(2)(c) if a licensee or applicant can demonstrate that an alternate method is available to ensure the residents' health, safety, and welfare.

1. The Department shall not grant an exception:
   a. From local building codes, local ordinances, local fire codes, or local zoning requirements;
   b. To a licensee operating on a provisional license; or
   c. If the Department determines that an exception will not protect the health, safety, or welfare of a resident.
2. An applicant or licensee shall submit a written request for an exception on a Department-provided form that includes:
   a. The applicant's or licensee's name;
   b. The name, address, and license number if applicable, of the assisted living facility;
   c. The specific rule the applicant or licensee is requesting an exception from;
   d. The reason or reasons an applicant is not able to comply with the rule; and
   e. An alternative method that ensures that the health, safety, and welfare of residents is protected by the exception.
3. The Department shall evaluate a request for an exception as follows:
   a. Review the written request;
   b. Verify submitted documentation;
   c. If the requested exception involves a physical plant requirement, inspect the assisted living facility; and
   d. If applicable, discuss the exception with the assisted living facility's manager or manager's designee, residents or representatives, or any individual the Department determines is necessary to evaluate the request.

G. The Department shall approve or deny an exception as follows:

1. The overall time-frame described in A.R.S. § 41-1072(2), is 90 days.
2. The administrative completeness review described in A.R.S. § 41-1072(1) is 60 days and begins on the date the Department receives a request.
   a. If any of the documents is missing or if information on the documents is deficient, the Department shall provide to the applicant a written notice of incompleteness that states each deficiency and the information or documents needed to complete the request. The 60 day time-frame for the Department to finish the administrative completeness review is suspended from the date the Department provides the notice of incompleteness to the applicant until the date the Department receives the required information or missing document.
   b. If all of the documents are submitted and the information on the documents is complete, the Department shall provide a written notice of administrative completeness to the applicant.
   c. If the documents or information are not submitted within 120 days from the date of notice of incompleteness, the Department shall consider the request withdrawn.
   d. If the Department grants an exception during the time provided to assess administrative completeness, the Department shall not provide a separate written notice of administrative completeness.
3. The substantive review time-frame described in A.R.S. § 41-1072(3) is 30 days and begins on the date the Department provides written notice of administrative completeness to the applicant.
   a. If the applicant does not meet the requirements of this Article the Department shall provide a written request for additional information to the applicant. The 30 day time-frame for the Department to finish the substantive review is suspended from the date the Department provides the written request to the applicant until the Department receives the additional information.
   b. The applicant shall submit to the Department the information or documents identified in the written request for additional information within 30 days of the receipt of the written request.
   c. The Department shall provide the applicant with a written notice of denial if:
      i. The applicant does not submit the additional information within the time-frame in subsection(D)(3)(b); or
      ii. Upon receipt of the additional information from the applicant, the Department determines that the applicant does not meet the requirements of this Article.
   d. An applicant may appeal the Department's determination according to A.R.S. Title 41, Chapter 6.
4. If an applicant meets the requirements of this Article, the Department shall provide a written notice of Department approval to the applicant.
5. The Department shall withdraw an exception if:
   a. A licensee is operating on a provisional license;
   b. A licensee does not comply with the conditions of the exception as approved by the Department; or
   c. The Department determines that the health, safety, or welfare of residents is not protected by the exception.

Historical Note

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exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

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R9-10-703. Administration

A. A licensee is responsible for the organization and management of an assisted living facility. A licensee shall:
1. Ensure compliance with federal and state laws, rules, and local ordinances;
2. Designate an on-site manager who has the authority and responsibility to operate the assisted living facility. The manager and the licensee may be the same individual;
3. Permit an individual to manage no more than 2 health care institutions that may be located not more than 40 miles apart;
4. Designate another manager when the manager is absent from the premises for more than 30 consecutive days;
5. Notify the Department, in writing, of the following:
   a. A change of ownership no later than 30 days before the effective date of the change;
   b. A change in the name of the assisted living facility no later than 30 days before the effective date of the change;
   c. A termination of operation no later than 30 days before the termination; and
   d. The location and arrangements for the maintenance of resident records no later than 30 days before the assisted living facility ceases operation;
6. Not act as a representative, agent, surrogate, health care power of attorney, power of attorney, guardian, or conservator of a resident who is not a relative and ensure that assisted living facility employees, support staff, or relatives of employees or support staff do not act as a representative, agent, surrogate, health care power of attorney, power of attorney, guardian, or conservator of a resident who is not a relative;
7. Ensure that a manager and each manager's designee is able to read, write, understand, and communicate in English;
8. Except when a resident's service needs change as documented in the resident's service plan as required in R9-10-711(A)(7), ensure that a resident receives at least 30 days written notice before any increase in a fee or charge;
9. Ensure that an official of the following agencies is allowed immediate access to an assisted living facility:
   a. The Department,
   b. A county health department,
   c. Adult Protective Services,
   d. The D.E.S. Long-Term Care Ombudsman, or
   e. A county or municipal fire department; and
10. Ensure that the following individuals have immediate access to a resident:
    a. The representative,
    b. The resident's case manager, or
    c. An individual assigned by a court of law to provide services to the resident.

B. A licensee shall ensure that a manager of an assisted living facility:
1. Develops and implements written policies and procedures for the day-to-day operation of the assisted living facility including:
   a. Depositing and refunding deposits, fees, and charges;
   b. Resolving resident grievances;
   c. Terminating residency;
   d. Obtaining information on resident preferences for:
      i. Social, recreational, or rehabilitative activities; and
      ii. Food;
   e. Assisting residents with medication as required in R9-10-713, R9-10-722(D), and R9-10-723(E), as applicable;
   f. Protecting and releasing resident records and maintaining confidentiality of resident records;
   g. Ensuring the facility and facility grounds are safe and free from hazards based upon the physical, cognitive, and functional condition of the residents;
   h. Ensuring resident safety in an assisted living facility with a swimming pool, spa, or other contained body of water on the premises, if applicable; and
   i. Ensuring the safety of residents and other individuals and pet and animal sanitation, if pets or animals are maintained on the premises;
2. Conspicuously posts the following:
   a. Resident rights;
   b. Current phone numbers of the Arizona Department of Health Services' Office of Assisted Living Licensure, D.E.S. Adult Protective Services, 911 or other local emergency response number, the D.E.S. Long-Term Care Ombudsman, the Arizona Center for Disability Law, and the Governor's Office for Americans with Disabilities;
   c. Internal facility requirements; and
   d. Each document, schedule, or calendar required by state law and this Article;
3. Ensures that each resident and each individual living in the facility provides documentation of freedom from pulmonary tuberculosis at least once every 12 months as required in R9-10-706(A)(1);
4. Designates, in writing, 1 or more individuals who are 21 years of age or older, who meet the qualifications for a caregiver in R9-10-706(C)(2) and (3) as the manager's designee. A manager's designee is physically present at the facility and in charge of the assisted living facility operations when the manager is not physically present at the facility;
5. Hires and directs employees and support staff as necessary to ensure compliance with this Article;
6. Ensures each assistant caregiver is under the direct supervision of a manager or caregiver at all times;
7. Ensures that an assistant caregiver, who is 16 or 17 years old, or a volunteer does not provide assistance to a resident for:
   a. Bathing,
   b. Toileting,
   c. Transfer,
   d. Self-administration of medication,
   e. Medication administration, or
   f. Nursing services;
8. Ensures that a manager or caregiver does not provide direct supervision to more than 2 assistant caregivers at any time;

9. Ensures compliance with fingerprinting requirements contained in A.R.S. § 36-411;
10. Notifies a representative, or contacts a public fiduciary or a trust officer to take responsibility of a resident's financial affairs if the resident is incapable of handling financial affairs;
11. Notifies a resident's primary care provider or other medical practitioner if a resident or the representative refuses medical or nursing services, and maintains documentation of the notification in the resident's record for no less than 12 months from the date of notification;
12. When there is an accident, incident, or injury that effects the resident's health and safety:
    a. Immediately notifies the representative, and if applicable:
        i. The primary care provider;
        ii. An emergency response team;
        iii. The resident's case manager;
        iv. The resident's emergency contact; and
    b. Documents the following:
        i. Date and time of the accident, incident, or injury;
        ii. Description of the accident, incident, or injury;
        iii. Names of individuals who observed the accident, incident, or injury;
        iv. Action taken by employees, support staff, or volunteers;
        v. Individuals notified by employees, support staff, or volunteers; and
        vi. Action taken to prevent the accident, incident, or injury from occurring in the future;
13. Ensures each resident is assisted in exercising the resident's rights listed in R9-10-710;
14. Maintains documentation on the premises of licensing and vaccination of pets or animals, if applicable, as required by R9-10-718(12); and
15. Ensures the health and safety of a resident is maintained during relocation of a resident and that the resident's records are relocated with the resident;

C. A manager may, upon written authorization by a resident or the representative, administer a personal funds account, not to exceed $500 each month for the resident. The resident or the representative may revoke, in writing, this authorization at any time. If a manager administers a resident's personal funds account, the manager shall:
1. Maintain a separate record for each resident's personal funds account including all receipts and expenditures;
2. Maintain the resident's personal funds account separate from any account of the assisted living facility; and
3. Provide a copy of a resident's personal funds account record to the resident or representative at least once every 3 months.

Historical Note

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Editor's Note: The following Section was repealed and a new Article adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on these rules (Supp. 98-4).

R9-10-704. Abuse, Neglect, and Exploitation Prevention and Reporting

A. A manager, employee, or volunteer shall immediately report or cause a report to be made to Adult Protective Services or local law enforcement of suspected or alleged abuse, neglect, or exploitation as required by A.R.S. § 46-454.

B. A licensee shall:
1. Notify the Department of suspected or alleged abuse, neglect, or exploitation within 24 hours of receiving the allegation;
2. Document the initial report and maintain documentation of the report on the premises for 12 months from the date of the report;
3. Report suspected or alleged abuse, neglect, or exploitation to Adult Protective Services or to a local law enforcement agency as prescribed in A.R.S. § 46-454; and
4. Investigate suspected or alleged abuse, neglect, or exploitation and develop a written report within 14 days of the initial report of the suspected or alleged abuse, neglect, or exploitation. The licensee shall send the written report to the Department, Adult Protective Services, and any local law enforcement agency previously notified and maintain a copy of the written report on the premises for 12 months from the date of the report. A written report shall contain the following:
    a. Dates, times, and description of the suspected or alleged abuse, neglect, or exploitation; description of any injury to the resident; change in the resident's physical, cognitive, functional, or emotional condition; actions taken by the licensee; individuals and agencies notified by the licensee; names of witnesses to the suspected or alleged abuse, neglect, or exploitation; and
    b. Action taken by the licensee to prevent the suspected or alleged abuse, neglect, or exploitation from occurring in the future.

Historical Note

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R9-10-705. Limitations on Level of Services

A licensee shall ensure that an assisted living facility does not accept or retain a resident who requires:

1. Physical restraints,
2. Chemical restraints,
3. Behavioral health residential services,
4. Services that the assisted living facility is not licensed to provide; or
5. Services that the assisted living facility is not able to provide.

Historical Note

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R9-10-706. Personnel Qualifications and Records

A. A licensee shall ensure that:

1. At the starting date of employment or service and every 12 months from the starting date of employment or service, each support staff and volunteer who interacts with a resident on a regular basis and each employee submits 1 of the following as evidence of being free from pulmonary tuberculosis:
   a. A report of a negative Mantoux skin test administered within 6 months of submitting the report; or
   b. A written physician's statement dated within 6 months of submitting the statement, indicating freedom from pulmonary tuberculosis, if the individual has had a positive skin test for tuberculosis;
2. Each manager and caregiver:
   a. Obtains first aid training specific to adults;
   b. Obtains CPR training specific to adults which includes a demonstration of the individual's ability to perform CPR; and
   c. Maintains current training in first aid and CPR.

B. A licensee shall ensure that a manager, at the starting date of employment as a manager, meets all of the following:

1. Is 21 years of age or older;
2. Is certified by the Board of Examiners as an assisted living facility manager as required in A.R.S. Title 36, Chapter 4, Article 6 or meets 1 of the following:
   a. Is certified by the Board of Examiners as an adult care home manager before the effective date of this Article and maintains current certification by the Board of Examiners; or
   b. Is exempt from certification under A.R.S. § 36-446.04;
3. Provides verification of completion of training from a training program as stated in R9-10-724(B) that states the individual has completed manager training or provides 1 of the following:
   a. Documentation of adult care home manager training from a Board of Examiners approved training program before the effective date of this Article;
   b. A license issued to the individual by the Board of Examiners as an administrator of a nursing care institution;
   c. Documentation of sponsorship of an adult foster care on the effective date of this Article; or
   d. Documentation of employment as a manager of an unclassified residential care institution, supportive residential living center, or supervisory care home on the effective date of this Article;
4. Provides verification of completion of training from a training program as stated in R9-10-724(B) that states the individual is trained in the level of service the assisted living facility is licensed to provide or documentation of 1 of the following:
   a. For supervisory care services, employment of the individual as a manager or caregiver of a supervisory care home on the effective date of this Article;
   b. For supervisory care services or personal care services, employment of the individual as a manager or caregiver of a supportive residential living center on the effective date of this Article;
   c. For supervisory care services, personal care services, or directed care services, 1 of the following:
      i. Documentation of training as a manager or caregiver from a Board of Examiners approved training program before the effective date of this Article;
      ii. A nursing care institution license issued by the Board of Examiners;
      iii. A nurse's license issued to the individual under A.R.S. Title 32, Chapter 15;
      iv. Documentation of employment as a manager or caregiver of an unclassified residential care institution on the effective date of this Article;
      v. Documentation of sponsorship of or employment as a caregiver in an adult foster care home on the effective date of this Article; or
      vi. A certificate as a nursing assistant in good standing under A.R.S. Title 32, Chapter 15 and employment as a caregiver in an adult care home on the effective date of this Article; and

5. Has a minimum of 12 months of health-related experience.

C. A licensee shall ensure that a caregiver, at the starting date of employment as a caregiver, meets all of the following:
1. Is 18 years of age or older;
2. Meets the training requirements in subsection (B)(4); and
3. Has a minimum of 3 months of health-related experience; and

D. A licensee shall ensure that an assistant caregiver, at the starting date of employment as an assistant caregiver, is 16 years of age or older.

E. A licensee shall ensure that a file is maintained on the premises for each employee containing the following:
1. The employee's name, date of birth, home address, and telephone number;
2. Documentation of:
   a. Freedom from pulmonary tuberculosis as required in subsection (A)(1);
   b. Compliance with fingerprinting requirements in R9-10-703(B)(9);
   c. Current training in CPR and first aid as required in subsection (A)(2);
   d. Employee qualifications required in subsections (B), (C), or (D);
   e. Employee orientation required in R9-10-707(A); and
   f. Ongoing training required in R9-10-707(B), R9-10-722(B), and R9-10-723(C), as applicable;
3. An employee's starting date of employment and ending date, if applicable; and
4. For each employee hired after the effective date of this Article, at least 2 personal and 2 professional or work-related references, if the employee has previous work experience, and documentation of the licensee's good faith effort to contact each reference.

F. A licensee shall ensure a file is maintained on the premises for each volunteer and support staff who has contact on a regular basis with residents that contains:
1. The individual's name, home address, and telephone number; and
2. Documentation of freedom from pulmonary tuberculosis as required in subsection (A)(1).

G. A licensee shall ensure that all records required by this Section are maintained throughout the individual's period of employment or service and for at least 12 months from the individual's last date of employment or service.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4). Section R9-10-706 repealed, new Section R9-10-706 adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed and a new Article adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on these rules (Supp. 98-4).

R9-10-707. Employee Orientation and Ongoing Training

A. A licensee shall ensure that a new employee completes orientation within 10 days from the starting date of employment that includes:
1. Orientation to the characteristics and needs of the assisted living facility's residents;
2. The assisted living facility's philosophy and goals;
3. Promotion of resident dignity, independence, self-determination, privacy, choice, and resident rights;
4. The significance and location of resident service plans, and how to read and implement a service plan;
5. Internal facility requirements and the assisted living facility's policies and procedures;
6. Confidentiality of resident records and resident information;
7. Infection control;
8. Food preparation, service, and storage, if applicable;
9. Abuse, neglect, and exploitation prevention and reporting requirements;
10. Accident, incident, and injury reporting; and
11. Fire, safety, and emergency procedures.

B. A licensee shall ensure that each manager and caregiver completes a minimum of 6 hours of ongoing training every 12 months from the starting date of employment, or for a manager or caregiver hired before the effective date of this Article, every 12 months from the effective date of this Article.
1. The training shall include:
   a. Promoting resident dignity, independence, self-determination, privacy, choice, and resident rights;
   b. Fire, safety, and emergency procedures;
   c. Infection control;
   d. Assistance in self-administration of medications; and
   e. Abuse, neglect, and exploitation prevention and reporting requirements;
2. Orientation for new employees, hours used in obtaining and maintaining current CPR and first aid, and hours used in obtaining initial training from a training program may count toward ongoing training for the 1st 12 months after the employee's starting date of employment.

Historical Note

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R9-10-708. Personnel Requirements

A. A licensee shall ensure there are sufficient personnel to provide the following unless Arizona Long-Term Care System contracts, as provided by A.R.S. Title 36, Chapter 29, Article 2, permit otherwise:
1. Supervisory care services, personal care services, or directed care services, consistent with the level of service the assisted living facility is licensed to provide;
2. Services established in each resident's service plan;
3. Services to meet the needs of each resident including scheduled and unscheduled needs, general supervision, and the ability to intervene in a crisis 24 hours a day;
4. Food services;
5. Environmental services required in R9-10-718;
6. Evacuations of residents during emergencies; and
7. Ongoing social, recreational, or rehabilitative activities.

B. A licensee shall ensure that a personnel schedule:
1. Indicates the date, scheduled work hours, and name of each employee assigned;
2. Reflects actual work hours; and
3. Is maintained on the premises for at least 12 months from the last date on the schedule.

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R9-10-709. Residency Agreements

A. The following requirements apply to a resident accepted into an assisted living facility after the effective date of this Article and to a resident who is not an enrolled member of the Arizona Long-Term Care System as provided by A.R.S. Title 36, Chapter 29, Article 2.

B. A licensee shall ensure that there is a written agreement signed by the licensee and any individual submitting a deposit or other pre-payment of fees before the licensee receives a deposit or other pre-payment of fees.

C. A licensee shall ensure that:
1. Each resident has a residency agreement that includes the:
   a. Terms of occupancy, including resident responsibilities and obligations;
   b. Services to be provided to the resident;
   c. The amount and purpose of any fee, charge, and deposit, including any fee or charge for any days a resident is absent from the assisted living facility;
   d. Services that are available at an additional fee or charge;
   e. Assisted living facility's policy for refunding fees, charges, or deposits;
   f. Assisted living facility's responsibility to provide at least 30 days written notice before the effective date of any change in a fee or charge. A licensee is not required to provide 30 day written notice of increase to a resident whose service needs change, as documented in the resident's service plan;
   g. Assisted living facility's policy and procedure for termination of residency; and
   h. Assisted living facility's grievance procedure;
2. A residency agreement is signed and dated by the manager or the manager's designee and the resident or the representative within 5 days after the resident's acceptance into the assisted living facility;
3. A copy of the residency agreement is given to the resident or the representative; and
4. A residency agreement that has been signed, as stated in subsection (C)(2), is maintained on the premises throughout the resident's residency at the assisted living facility.

D. If a licensee receives a deposit or pre-payment of fees from a resident or a representative, the licensee shall ensure that:
1. Except for a Life Care Contract regulated under A.R.S. Title 20, Chapter 8, a deposit does not exceed the amount of 1 month's fees;
2. A deposit is maintained in a bank account separate from the assisted living facility's operating expenses;
3. A deposit or portion of a deposit is not used for any purpose other than as stated in the resident's residency agreement; and
4. Only the following are deducted from the deposit:
   a. Damages to property caused by the resident, excluding normal wear and tear;
   b. A fee or charge incurred by the resident; or
   c. The resident's documented non-compliance with the residency agreement.

E. A licensee or resident may terminate residency as follows:
1. A licensee may terminate residency of a resident without notice if:
   a. The resident exhibits behavior that is an immediate threat to the health and safety of the resident or other individuals in the assisted living facility;
   b. The resident's urgent medical or health needs require immediate transfer to another health care institution; or
   c. The resident's care and service needs exceed the services the assisted living facility is licensed to provide;

2. A licensee may terminate residency of a resident after providing 14 days written notice to the resident or the representative for 1 of the following reasons:
   a. Documentation of failure to pay fees or charges;
   b. Documentation of the resident's non-compliance with the residency agreement or internal facility requirements;
3. Except as provided by subsection (E)(1) and (2), a licensee shall not terminate residency of a resident without providing the resident or the representative 30 days written notice;
4. A resident or the representative may terminate residency of a resident without notice due to the following, as substantiated by a governmental agency:
   a. Neglect;
   b. Abuse;
   c. Exploitation; or
   d. Conditions of imminent danger to life, health, or safety; and
5. A resident or the representative may terminate residency of a resident after providing 14 days written notice to the licensee for documentation of the licensee's failure to comply with the resident's service plan or residency agreement.

F. A licensee shall ensure that a written notice of termination of residency includes:
1. The reason for the termination of residency;
2. The effective date of the termination of residency;
3. The resident's right to grieve the termination of residency;
4. The assisted living facility's grievance procedure; and
5. The assisted living facility's refund policy.

G. A licensee shall provide the following to a resident or a representative upon issuing a written notice of termination of residency:
1. A copy of the resident's service plan;
2. Documentation that the resident is free from pulmonary tuberculosis; and
3. The phone numbers and addresses of the local area agency on aging and D.E.S. Long-Term Care Ombudsman.

H. A licensee shall not request or retain fees as follows:
1. If a resident dies or if a resident or representative terminates residency as permitted in subsection (E)(4), a licensee shall not request or retain fees after the date of the resident's death or termination of residency;
2. If termination of residency occurs as permitted in subsection (E)(1), (2), or (5), a licensee shall not request or retain fees for more than 14 days from the date the written notice was received by the assisted living facility; and
3. For reasons other than identified in subsection (H)(1) and (2), the licensee shall not request or retain fees for more than 30 days after termination of residency.

I. Within 30 days after the date of termination of residency, a licensee shall provide to the resident, the representative, or the individual to be contacted in the event of a significant change in the resident's condition:
1. A written statement that includes:
   a. The disposition of the resident's personal property;
   b. An accounting of all fees, personal funds, or deposits owed to the resident; and
   c. An accounting of any deduction from fees or deposits; and
2. All fees or deposits required by this Section and personal funds.

Historical Note

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R9-10-710. Resident Rights

A. A licensee shall ensure that a resident or representative is provided the following at the time the resident is accepted into an assisted living facility:
1. A list of current resident rights;
2. A copy of current internal facility requirements; and
3. Current phone numbers of:
   a. The Arizona Department of Health Services' Office of Assisted Living Licensure;
   b. D.E.S. Adult Protective Services;
   c. 911 or other local emergency response;
   d. The D.E.S. Long-Term Care Ombudsman;
   e. The Arizona Center for Disability Law;
   f. The Governor's Office for Americans with Disabilities; and
   g. An entity that provides information on health care directives.

B. A licensee shall ensure that a resident or the representative acknowledges, in writing, receipt of the items in subsection (A).

C. A licensee shall ensure that language barriers or physical disabilities do not prevent a resident or representative from becoming aware of internal facility requirements and the resident rights.

D. A licensee shall ensure that a resident has the following rights:
1. To live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice;
2. To be treated with consideration and respect;
3. To be free from abuse, neglect, exploitation, and physical restraints and chemical restraints;
4. To privacy in correspondence, communications, visitation, financial and personal affairs, hygiene, and health-related services;
5. To receive visitors and make private phone calls;
6. To participate or allow the representative or other individual to participate in the development of a written service plan;

7. To receive the services specified in the service plan, and to review and re-negotiate the service plan at any time;
8. To refuse services, unless such services are court ordered or the health, safety, or welfare of other individuals is endangered by the refusal of services;
9. To maintain and use personal possessions, unless such use infringes upon the health, safety, or welfare of other individuals;
10. To have access to common areas in the facility;
11. To request to relocate or refuse to relocate within the facility based upon the resident's needs, desires, and availability of such options;
12. To have financial and other records kept in confidence. The release of records shall be by written consent of the resident or the representative, except as otherwise provided by law;
13. To review the resident's own records during normal business hours or at a time agreed upon by the resident and the manager;
14. To review a copy of this Article during normal business hours or at a time agreed upon by the resident and the manager;
15. To review the assisted living facility's most recent survey conducted by the Arizona Department of Health Services, and any plan of correction in effect during normal business hours or at a time agreed upon by the resident and the manager;
16. To be informed, in writing, of any change to a fee or charge at least 30 days before the change, unless the resident's service needs change, as documented in the resident's service plan as required in R9-10-711(A)(7);
17. To submit grievances to employees, outside agencies, and other individuals without constraint or retaliation;
18. To exercise free choice in selecting activities, schedules, and daily routines;
19. To exercise free choice in selecting a primary care provider, pharmacy, or other service provider and assume responsibility for any additional costs incurred as a result of such choices;
20. To perform or refuse to perform work for the assisted living facility;
21. To participate or refuse to participate in social, recreational, rehabilitative, religious, political, or community activities; and
22. To be free from discrimination in regard to race, color, national origin, sex, sexual orientation, and religion and to be assured the same civil and human rights accorded to other individuals.

Historical Note

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R9-10-711. Requirements for Service Plans and Health-Related Services

A. A licensee shall ensure that a resident has a written service plan that:
1. Is initiated the day a resident is accepted into the assisted living facility;
2. Is completed no later than 14 days after the resident's date of acceptance;
3. Is developed with assistance and review from:
   a. The resident or representative;
   b. The manager or manager's designee;
   c. A nurse, if the resident is receiving nursing services, medication administration, or is unable to direct self-care;
   d. The resident's case manager, if applicable;
   e. Any individual requested by the resident or the representative; and
   f. If applicable and necessary, any of the following: caregivers, assistant caregivers, the resident's primary care provider, or other medical practitioner;
4. Is based on an assessment conducted with resident interaction and by the individuals in subsection (A)(3);
5. Includes the following:
   a. The level of service the resident is receiving;
   b. The amount, type, and frequency of health-related services needed by the resident; and
   c. Each individual responsible for the provisions of the service plan;
6. Is signed and dated by:
   a. The resident or the representative;
   b. The manager or the manager's designee;
   c. The nurse, if a nurse assisted in the preparation or review of the plan; and
   d. The case manager, if a case manager assisted in the preparation or review of the plan; and
7. Is updated according to the requirements in subsection (A)(3) through (6):
   a. No later than 14 days after a significant change in the resident's physical, cognitive, or functional condition; and
   b. As follows:
      i. At least once every 12 months for a resident receiving supervisory care services;
      ii. At least once every 6 months for a resident receiving personal care services; and
      iii. At least once every 3 months for a resident receiving directed care services.

B. A licensee shall ensure that a resident is provided the following, consistent with the level of service the assisted living facility is licensed to provide:
1. Supervisory care services, personal care services, or directed care services specified in the resident's service plan;
2. Supervisory care services, personal care services, or directed care services to meet a resident's scheduled and unscheduled needs;

3. General supervision to ensure crisis intervention during an emergency, accident, incident, illness, or significant change in the resident's physical, functional, or cognitive condition;
4. Supervisory care services, personal care services, or directed care services that promote a resident's independence, dignity, choice, self determination, and the resident's highest physical, cognitive, and functional capability;
5. Assistance in utilizing community resources, as applicable;
6. Encouragement and assistance to preserve outside support systems; and
7. Social interaction to maintain identity and self-worth.

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R9-10-712. Activity Programs

A. A licensee shall ensure that daily social, recreational, or rehabilitative activities are provided as follows:
1. Activities are planned according to residents' preferences, needs, and abilities;
2. A calendar of activities:
   a. Is prepared at least 1 week in advance from the date the activity is provided;
   b. Is conspicuously posted;
   c. Reflects all substitutions in activities provided; and
   d. Is maintained on the premises for 12 months after the last scheduled activity; and
3. Equipment and supplies are available and accessible to accommodate each resident who chooses to participate in an activity.

B. A licensee shall ensure that daily newspapers, current magazines, and a variety of reading materials are available and accessible to a resident at an assisted living facility.

Historical Note
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R9-10-713. Medications

A. A licensee shall ensure that a resident's service plan states whether the resident:
1. Requires no assistance in the self-administration of medication or medication administration;
2. Needs assistance in the self-administration of medication which includes 1 or more of the following:
   a. Storing a resident's medication;
   b. Reminding a resident that it is time to take a medication;
   c. Reading the medication label to a resident to:
      i. Confirm the medication is being taken by the individual it is prescribed for;
      ii. Check the dosage against the label on the container and reassure the resident that the dosage is correct; and
      iii. Confirm the resident is taking the medication as directed;
   d. Opening the medication container for a resident;
   e. Pouring or placing a specified dosage into a container or into the resident's hand; or
   f. Observing the resident while the medication is taken; or
3. Needs medication administration.

B. A licensee shall ensure that:
1. An assisted living facility's medication policies and procedures are approved by a physician, pharmacist, or RN and address:
   a. Obtaining and refilling medication;
   b. Storing and controlling of medication;
   c. Disposing of medication;
   d. Assisting in the self-administration of medication and medication administration, as applicable; and
   e. Recording of medication assistance provided to residents and maintenance of medication records;
2. A drug reference guide, no older than 2 years from the copyright date, is available and accessible for use by employees;
3. Medication stored by the licensee is stored or controlled as follows:
   a. Medication is stored in a locked container, cabinet, or area that is inaccessible to residents;
   b. Medication is not left unattended by an employee;
   c. Medication is stored in the original labeled container, except for medication organizers, and according to instructions on the medication label;
   d. A bathroom or laundry room is not used for medication storage; and
   e. All expired or discontinued medication, including those of deceased residents, are disposed of according to the assisted living facility's medication policies and procedures;
4. Medication stored by a resident in the resident's room or unit is stored and controlled as follows:
   a. Medication is kept in a locked container or cabinet or a resident locks the entrance to the room or unit when the resident is not in the room or unit and an employee has a key and access to the resident's room or unit and medication storage container or cabinet; or
   b. As stated in the resident's service plan;
5. Except for medication organizers, resident medication is not pre-poured. Medication organizers may be prepared up to 4 weeks in advance by the following individuals:
   a. A resident or the representative;
   b. A resident's relatives;
   c. A nurse; or
   d. As otherwise provided by law; and
6. A separate medication record is maintained for each resident receiving assistance in self-administration of medication or medication administration that includes:

a. Name of resident;
b. Name of medication, dosage, directions, and route of administration;
c. Date and time medication is scheduled to be administered;
d. Date and time of actual assistance in self-administration of medication or medication administration; and
e. Signature or initials of the employee providing assistance in self-administration of medication or medication administration.

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R9-10-714. Resident Records

A. A licensee shall maintain a resident's record that contains:
1. The resident's name and social security number;
2. The date of resident's acceptance into the assisted living facility, source of referral to the assisted living facility, and last address of resident;
3. The names, addresses, and telephone numbers of the following:
   a. The representative, if applicable;
   b. The resident's primary care provider;
   c. The resident's case manager, if applicable;
   d. Each medical practitioner providing health-related services or medical services to the resident; and
   e. An individual or relative to be contacted in the event of emergency, significant change in the resident's condition, or termination of residency;
4. The residency agreement and any amendments;
5. The documentation of the receipt of internal facility requirements, resident rights, and community phone numbers as required in R9-10-710(B);
6. The documentation of orientation to the evacuation plan as required in R9-10-717(B);
7. The service plan, its amendments and updates;
8. A health care directive, if applicable;
9. Documentation of freedom from pulmonary tuberculosis as required in R9-10-703(B)(3);
10. Any orders from a primary care provider or medical practitioner as required in R9-10-722 or R9-10-723;
11. The medication records as required in R9-10-713(B)(6);
12. Accident, incident, or injury reports as required in R9-10-703(B)(12);
13. Written authorizations for residency or continued residency as required by R9-10-722(A)(3) and (4) and R9-10-723(B)(1) and (3);
14. Documentation of any change in a resident's behavior, physical, cognitive, or functional condition and action taken by employees to address the resident's changing needs;
15. A written notice of termination of residency, if applicable;
16. The address and phone number of the resident's new place of residence, if applicable;
17. Documentation of relocation assistance provided to the resident, if applicable; and
18. Documentation of the disposition of the resident's personal property and monies owed to the resident as required in R9-10-709(I)(1), if applicable.

B. A licensee shall ensure that a resident's record is:
1. Confidential and only released with written permission from the resident or the representative, or as otherwise provided by law;
2. Maintained at the facility;
3. Legibly recorded in ink or electronically recorded;
4. Retained for 3 years from the date of termination of residency; and
5. Available for review by the resident or the representative during normal business hours or at a time agreed upon by the resident and the manager.

C. A licensee shall ensure that a resident's financial records are maintained separate from a resident's record and are only accessible to individuals designated by the licensee.

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R9-10-715. Food Services

A. A licensee shall ensure that:
1. Three meals a day, served with not more than a 14 hour span between the evening meal and morning meal, and 1 snack a day is available to residents, unless otherwise prescribed by a therapeutic diet;
2. Meals and snacks meet each resident's nutritional needs based upon the resident's age and health needs;
3. Menus are:
   a. Based on:
      i. Resident food preferences, eating habits, customs, health conditions, appetites, and religious, cultural, and ethnic backgrounds; and
      ii. The Food Guide Pyramid, USDA, Center for Nutrition Policy and Promotion, Home and Garden Bulletin Number 252, Revised October 1996, incorporated by reference and on file with the Department and the Office of the Secretary of State. This incorporation by reference contains no future additions or amendments;
   b. Prepared at least 1 week before the date the food is served;
   c. Dated and conspicuously posted; and
   d. Maintained on the premises for at least 60 days from the date on the menu;
4. Meals and snacks provided by the assisted living facility are served according to preplanned menus. Substitutions to the pre-planned menu are stated on the menu;
5. Meals and snacks on each posted menu contain a variety of foods from each food group in the Food Guide Pyramid;
6. A 3 day supply of perishable and a 3 day supply of nonperishable foods is maintained on the premises; and

7. Water is available and accessible to residents at all times.

B. If the assisted living facility offers therapeutic diets, a licensee shall ensure that:
1. A therapeutic diet manual, no older than 5 years from the copyright date, is available and accessible for use by employees; and
2. The therapeutic diet is provided to a resident according to a written order from the resident's physician or as otherwise provided by law.

C. A licensee shall ensure that food is obtained, prepared, served, and stored as follows:
1. Food is free from spoilage, filth, or other contamination and is safe for human consumption;
2. Food is protected from potential contamination;
3. Except for food from a garden or orchard, food is obtained only from sources that comply with all laws relating to food and food labeling. A licensee shall ensure that any canned food is commercially canned;
4. Potentially hazardous food is maintained as follows:
   a. Foods requiring refrigeration are maintained at 41° F or below;
   b. Foods requiring cooking are cooked to heat all parts of the food to a temperature of at least 140° F, except that:
      i. Ground beef, poultry, poultry stuffing, stuffed meats and stuffing containing meat are cooked to heat all parts of the food to at least 165° F;
      ii. Pork and any food containing pork are cooked to heat all parts of the food to at least 155° F;
      iii. Rare roast beef is cooked to an internal temperature of at least 140° F and rare beef steak is cooked to a temperature of at least 130° F unless otherwise requested by a resident; and
      iv. Leftovers are reheated to a temperature of 165°;
5. A refrigerator contains a thermometer, accurate to + or - 3° F at the warmest part of the refrigerator;
6. Raw fruits and raw vegetables are rinsed with water before being cooked or served;
7. Food is stored in covered containers, a minimum of 6 inches above the floor, and protected from splash and other contamination;
8. Frozen foods are stored at a temperature of 0° F or below;
9. Food service is not provided by an individual infected with a communicable disease that may be transmitted by food handling or in which there is a likelihood of the individual contaminating food or food-contact surfaces or transmitting disease to other individuals;
10. Before starting work, after smoking, using the toilet, and as often as necessary to remove soil and contamination, individuals providing food services wash their hands and exposed portions of their arms with soap and warm water; and
11. Tableware, utensils, equipment, and food-contact surfaces are clean and in good repair.

Historical Note
Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on these rules (Supp. 98-4).

R9-10-716. Physical Plant Requirements

A. A licensee shall ensure that an assisted living facility:
1. Complies with all local building codes, ordinances, fire codes, and zoning requirements. If there are no local building codes, ordinances, fire codes, or zoning requirements, the assisted living facility complies with the applicable codes and standards incorporated by reference in A.A.C. R9-1-412;
2. Is hazard-free;
3. Has a common area and a dining area that:
   a. Are not converted, partitioned, or otherwise used as a sleeping area; and
   b. Contain furniture to accommodate the recreational and socialization needs of residents and other individuals in the assisted living facility;
4. Provides at least 1 bathroom, containing at least a flushable toilet and a sink, that is accessed from a common area;
5. Provides a hazard-free outdoor area with shaded protection where residents may walk or sit; and
6. Provides wheelchair ramps or other access from exterior doors for residents using wheelchairs or other assistive devices.

B. A licensee shall ensure that:
1. No more than 2 individuals reside in a residential unit or bedroom. An assisted living facility that provides documentation of operating before the effective date of this Article with more than 2 individuals living in a unit or bedroom may continue to allow more than 2 individuals to reside in a unit or bedroom if there is 60 square feet or more for each individual living in the unit or bedroom;
2. A bedroom or unit is not used to access a common room, common bathroom, or another bedroom or unit unless written consent is obtained from the resident or the representative;
3. To provide natural light, a bedroom or unit has:
   a. A window to the outside; or
   b. A door made of glass to the outside; and
4. To provide safe egress in an emergency, a bedroom or unit has:
   a. A window that either:
      i. Meets the requirements of the local jurisdiction; or
      ii. Has no dimension less than 20 inches, is at least 720 square inches, and has a window sill that is no more than 44 inches off the floor; or
   b. A door to the outside.

C. A licensee shall ensure that a swimming pool on the premises of an assisted living facility:
1. Complies with all applicable laws and rules for swimming pool construction and safety and:
   a. Is enclosed by a 5 foot solid wall, fence, or barrier with either vertical or horizontal open spaces that do not exceed 4 inches; or
   b. Is inaccessible to residents and is granted an exception as prescribed in R9-10-702(F) from the enclosure requirements in subsection (C)(1)(a); and
2. Has self-closing, self-latching gates that are kept locked when the swimming pool is not in use; and
3. Has pool safety requirements conspicuously posted in the swimming pool area.

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tion from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

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R9-10-717. Fire and Safety Requirements

A. A licensee shall ensure that:
1. A written evacuation plan is developed and maintained on the premises;
2. A written disaster plan, identifying a relocation plan for all residents from the facility, is developed and maintained on the premises;
3. An employee fire drill is conducted at least once every 3 months on each shift. Residents are not required to participate in an employee fire drill. An employee fire drill includes making a general announcement throughout the facility that an employee fire drill is being conducted or sounding a fire alarm;
4. A resident fire drill is conducted at least once every 6 months and includes residents, employees on duty, support staff on duty, and other individuals in the facility. A resident fire drill includes making a general announcement throughout the facility that a resident fire drill is being conducted or sounding a fire alarm; and
5. Records of employee fire drills and resident fire drills are maintained on the premises for 12 months from the date of the drill and include the date and time of the drill, names of employees participating in the drill, and identification of residents needing assistance for evacuation.

B. A licensee shall ensure that a resident receives orientation to the evacuation plan within 24 hours of the resident's acceptance into the assisted living facility. Documentation of the orientation shall be signed and dated by the resident or the representative.

Historical Note

Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

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R9-10-718. Environmental Services

A licensee shall ensure that:
1. A facility and facility grounds are:
   a. In good repair;
   b. Clean;
   c. Free of odors;
   d. Free of any object, material or condition that may be a hazard based on the physical, cognitive, and functional condition of the residents; and
   e. Free of insects and rodents;
2. Garbage and refuse are:
   a. Stored in covered containers lined with plastic bags; and
   b. Removed from the premises at least once a week;
3. Heating and cooling systems maintain the facility at a temperature between 68° F to 85° F at all times. A resident with an individual temperature-controlled residential unit or room may heat and cool to provide for individual comfort;
4. Common areas are lighted to assure safety of residents;
5. Hot water temperatures are maintained between 95° F and 120° F in the areas of a facility used by residents;
6. The supply of hot and cold water is sufficient to meet the personal hygiene needs of residents;
7. A common bathroom has toilet paper; soap; and cloth towels, paper towels, or a mechanical air hand dryer accessible to residents;
8. Soiled linen and soiled clothing stored by the assisted living facility are stored in closed containers away from food storage, kitchen, and dining areas;
9. Oxygen containers are maintained in an upright position;
10. Poisonous or toxic materials stored by the assisted living facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications;
11. Combustible or flammable liquids and hazardous materials stored by an assisted living facility are stored in the original labeled containers or safety containers outside the facility or in an attached garage locked and inaccessible to residents;
12. Pets or animals are:
    a. Controlled to prevent endangering the residents and to maintain sanitation;
    b. Licensed consistent with local ordinances;
    c. Vaccinated as follows:
       i. A dog is vaccinated against rabies, leptospirosis, distemper, hepatitis, and parvo; and
       ii. A cat is vaccinated against rabies and feline leukemia;
13. A container with first-aid supplies, in a quantity sufficient to meet the needs of all residents, is accessible to employees. First-aid supplies include at least band-aids, sterile bandages or gauze pads, antiseptic solution, tweezers, scissors, tape, and disposable latex gloves;
14. If a non-municipal water source is used, the water source is tested at least once every 12 months for total coliform bacteria and fecal coliform or E. Coli bacteria and corrective action is taken to ensure the water is safe to drink. Documentation of testing is retained on the premises for 24 months from the date of the test; and
15. If a non-municipal sewage system is used, the sewage system is in working order and is maintained according to all applicable state laws and rules.

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R9-10-719. Supplemental Requirements for an Assisted Living Home

A. In addition to the requirements in R9-10-716, a licensee shall ensure that an assisted living home meets the following:
1. Each bedroom is of standard construction with walls from floor to ceiling with at least 1 door. If a bedroom door is capable of being locked from the inside, an employee shall have a key and access to the bedroom at all times;
2. There is at least 80 square feet of floor space, excluding closets, bathrooms, alcoves, or vestibules, for a resident in a private bedroom and at least 60 square feet of floor space excluding closets, bathrooms, alcoves, or vestibules, for each resident sharing a bedroom with another individual;
3. A bedroom used by a resident who is receiving personal care services or directed care services is equipped with a bell, intercom, or other mechanical means to alert employees to a resident's needs or emergencies;
4. Unless the resident provides the resident's own furnishings, a licensee provides the following furnishings for a resident:
   a. A bed, 36 inches wide or larger, consisting of at least a frame and mattress that is clean and in good repair;
   b. Clean linen including mattress pad, sheets large enough to tuck under the mattress, pillows, pillow cases, bedspread, waterproof mattress covers as needed, and blankets to ensure warmth and comfort for each resident;
   c. A bedside lamp that provides light for reading;
   d. Storage space for clothing;
   e. Individual storage space for personal effects; and
   f. Adjustable window covers that provide resident privacy;
5. A bathroom meets the following requirements:
   a. There is at least 1 working flushable toilet and 1 working sink for each 8 individuals living in the home;
   b. There is 1 working tub or shower for each 8 individuals living in the home;
   c. The sink is in the same bathroom as the toilet or in a room adjacent to the toilet, and is not used for food preparation;
   d. Each bathroom provides privacy when in use and contains:
      i. A mirror, unless the resident's service plan requires otherwise;
      ii. A means of ventilation or an operable window;
      iii. Nonporous surfaces for shower enclosures, clean usable shower curtains, and slip-resistant surfaces in tubs and showers; and
      iv. Grab bars for the toilet and tub or shower and other assistive devices, if required in a resident's service plan, to provide for resident safety; and
   e. If a bathroom has a door locking from the inside, an employee has key and access to the bathroom at all times;
6. A resident is not housed on a floor that does not open onto the ground level unless:
   a. There is a secondary means of emergency exit that the resident is capable of using; and
   b. The resident is ambulatory without assistance and is able to direct self-care;
7. A resident has access to laundry service or a washing machine and dryer in the home.

B. In addition to the fire and safety requirements contained in R9-10-717, a licensee shall ensure the following:
1. A written evacuation plan, identifying interior exits, is conspicuously posted in the home;
2. A portable, all-purpose fire extinguisher that meets at a minimum, a 2A-10-BC rating of the Underwriter's Laboratories as described in Publication 10 of the National Fire Code, incorporated by reference in A.A.C. R9-1-412 is installed and maintained in the home as prescribed by the fire authority having jurisdiction;
3. A fire extinguisher is:
   a. Serviced every 12 months or as recommended by the manufacturer;
   b. Tagged specifying the date of recharging and the name of the organization performing the work; and
   c. Placed on wall brackets so that the top handle of the fire extinguisher is not over 5 feet from the floor and the bottom of the fire extinguisher is at least 4 inches off the floor;
4. Smoke detectors are installed according to the manufacturer's instructions in at least the following areas:
   a. Bedrooms;
   b. Hallways that adjoin bedrooms;
   c. Storage rooms and laundry rooms;
   d. Attached garages;
   e. Rooms or hallways adjacent to the kitchen; and
   f. Other places recommended by the manufacturer;
5. Smoke detectors that are battery-operated are equipped with a device that warns of a low battery. If more than 2 violations of an inoperative battery-operated smoke detector are cited in a 24 month period, the licensee shall ensure the smoke detector is hard wired into the electrical system; and
6. Smoke detectors are inspected as often as recommended by the manufacturer and kept in working order.

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R9-10-720. Supplemental Requirements for an Assisted Living Center

A. In addition to the requirements in R9-10-716, a licensee shall ensure that a center or a portion of a center providing personal care services or directed care services:
1. Has a fire alarm system installed according to the National Fire Protection Association 72: National Fire Alarm Code, Chapter 3, Section 3-4.1.1(a), incorporated by reference in A.A.C. R9-1-412, and a sprinkler system installed according to the National Fire Protection Association 13 standards incorporated by reference in A.A.C. R9-1-412; or
2. Has an alternative method to ensure the resident's safety approved by the local jurisdiction and granted an exception as prescribed in R9-10-702(F).

B. A licensee shall ensure that a resident has access to a laundry service or a washing machine and dryer in the center.

C. A licensee shall ensure that a resident's sleeping area is contained in a residential unit or a bedroom.

1. A residential unit shall meet the following:
   a. Have at least 220 square feet of floor space, excluding the bathroom and closet, for 1 individual and an additional 100 square feet of floor space, excluding the bathroom and closet, for a 2nd individual;
   b. Have an individually keyed entry door. A key shall be provided to the resident or the representative, and an employee shall have a key and access to the unit at all times;
   c. A unit used by a resident receiving personal care services or directed care services shall be equipped with a bell, intercom, or other mechanical means to alert employees to a resident's needs or emergencies. A licensee may request an exception from this requirement as prescribed in R9-10-702(F) for a resident who is unable to direct self-care if there is an alternative method of communication;
   d. Have a bathroom that provides privacy when in use and contains:
      i. A working flushable toilet;
      ii. A working sink;
      iii. A working tub or shower;
      iv. A mirror, unless the resident's service plan requires otherwise;
      v. A means of ventilation or an operable window;
      vi. Nonporous surfaces for shower enclosures, clean usable shower curtains, and slip-resistant surfaces in tubs and showers; and
      vii. Grab bars for the toilet and tub or shower and other assistive devices, if identified in a resident's service plan, to provide for resident safety;
   e. If a bathroom has a door locking from the inside, an employee has a key and access to the bathroom at all times;
   f. Contains a resident-controlled thermostat for heating and cooling;
   g. Contains a kitchen area equipped with:
      i. A working sink;
      ii. A working refrigerator;
      iii. A cooking appliance that can be removed or disconnected;
      iv. Space for food preparation; and
      v. Storage for utensils and supplies;
   h. Unless the resident provides the resident's own furnishings, the licensee provides the following furnishings for a resident:
      i. A bed, 36 inches wide or larger, consisting of at least a frame and mattress that is clean and in good repair;
      ii. Clean linen including mattress pad, sheets large enough to tuck under the mattress, pillows, pillow cases, bedspread, waterproof mattress covers as needed, and blankets to ensure warmth and comfort for each resident;
      iii. A bedside lamp that provides light for reading;
      iv. Storage space for clothing;
      v. Individual storage space for personal effects;
      vi. Adjustable window covers that provide resident privacy;
      vii. One armchair or side chair; and
      viii. One table where a resident may eat a meal.
2. A bedroom shall meet the following:
   a. Is of standard construction with walls from floor to ceiling with at least 1 door. If a bedroom door is capable of being locked from the inside, an employee has a key and access to the bedroom at all times;
   b. There is at least 80 square feet of floor space, excluding closets, bathrooms, alcoves, or vestibules, for a resident in a private bedroom and at least 60 square feet of floor space, excluding closets, bathrooms, alcoves, or vestibules for each resident sharing a bedroom with another individual;
   c. A bedroom used by a resident receiving personal care services or directed care services is equipped with a bell, intercom, or other mechanical means to alert employees to the resident's needs or emergencies. A licensee may request an exception from this requirement as prescribed in R9-10-702(F) for a resident who is unable to direct self-care if there is an alternative method of communication;
   d. Unless the resident provides the resident's own furnishings, the licensee provides the following furnishings for a resident:
      i. A bed, 36 inches wide or larger, consisting of at least a frame and mattress that is clean and in good repair;
      ii. Clean linen including mattress pad, sheets large enough to tuck under the mattress, pillows, pillow cases, bedspread, waterproof mattress covers as needed, and blankets to ensure warmth and comfort for each resident;
      iii. A bedside lamp that provides light for reading;
      iv. Storage space for clothing;
      v. Individual storage space for personal effects; and
      vi. Adjustable window covers that provide resident privacy;
   e. Bathroom requirements:
      i. At least 1 working flushable toilet and 1 working sink for each 8 individuals living in the center;
      ii. One working tub or shower for each 8 individuals in the center; and
      iii. The sink may be in the same bathroom as the toilet or in a room adjacent to the toilet but is not used for food preparation;
   f. Each bathroom provides privacy when in use and contains:
      i. A mirror, unless the resident's service plan requires otherwise;
      ii. A means of ventilation or an operable window;
      iii. Nonporous surfaces for shower enclosures, clean usable shower curtains, and slip-resistant surfaces in tubs and showers; and
      iv. Grab bars for the toilet and tub or shower and other assistive devices, identified in the resident's service plan, to provide for resident safety; and
   g. For a bathroom door locking from the inside, an employee has a key and access to the bathroom at all times.

D. A licensee shall obtain the following inspections of a facility, according to the following schedules, and make any repairs or corrections stated on an inspection report:

1. Sanitation inspections, conducted a minimum of every 12 months by a local health department; and

2. Fire inspections, conducted no less than every 36 months by a local fire department or the State Fire Marshal.

E. A licensee shall maintain current reports of sanitation and fire inspections on the facility premises.

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R9-10-721. Supplemental Requirements for an Assisted Living Facility Licensed to Provide Supervisory Care Services
A resident in an assisted living facility that is licensed to provide supervisory care services may receive nursing services or health-related services from a licensed home health agency, licensed hospice service agency, or private duty nurse.

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R9-10-722. Supplemental Requirements for an Assisted Living Facility Licensed to Provide Personal Care Services

A. A licensee of an assisted living facility licensed to provide personal care services shall not:
1. Accept or retain a resident unable to direct self-care;
2. Accept or retain an individual who requires continuous nursing services unless:
   a. The resident is under the care of a licensed hospice service agency;
   b. The continuous nursing services are provided by a private duty nurse; or
   c. The assisted living facility meets the requirements of A.R.S. § 36-401(C);
3. Accept or retain a resident who is bedbound unless:
   a. The condition is a result of a short-term illness or injury; or
   b. The following requirements are met at the onset of the condition or when the resident is accepted into the assisted living facility:
      i. Written authorization of residency or continued residency is signed and dated by the resident or the representative;
      ii. The resident's primary care provider, who has examined the resident within 30 days from the onset of the condition or upon acceptance into the assisted living facility, signs and dates a statement authorizing residency at the assisted living facility. The resident's primary care provider shall examine the resident at least once every 6 months throughout the duration of the resident's condition and signs and dates a statement authorizing continued residency;
      iii. The resident does not require continuous nursing services except as provided by subsection (A)(2);
      iv. The resident's service plan is revised to include the resident's increased need for services;
      v. The resident is under the care of a nurse, licensed home health agency, or licensed hospice service agency;
      vi. The assisted living facility is meeting the resident's needs; and
      vii. The assisted living facility documents the services provided to the resident to meet the resident's needs; and
4. Accept or retain a resident who has a stage 3 or stage 4 pressure sore, as determined by a nurse or medical practitioner, unless the assisted living facility meets the requirements in subsection (A)(3)(b).

B. In addition to the ongoing training requirements in R9-10-707 (B), a licensee of an assisted living facility licensed to provide personal care services shall ensure that each manager and caregiver completes a minimum of 2 hours of ongoing training in providing personal care services every 12 months from the starting date of employment, or for a manager or caregiver hired before the effective date of this Article, every 12 months from the effective date of this Article.

C. A licensee shall provide to each resident receiving personal care services:
1. Skin maintenance to prevent and treat bruises, injuries, pressure sores, and infections;
2. Sufficient fluids to maintain hydration;
3. Incontinence care that ensures that a resident maintains the highest practicable level of independence and dignity when toileting;
4. An assessment conducted by a primary care provider of each resident who needs medication administration or nursing services within 30 days of being accepted into the assisted living facility or within 30 days of developing the need for nursing services or medication administration; and
5. Documentation of a resident's weight for each resident receiving medication administration or nursing services. A resident's weight shall be recorded in the resident's service plan when a resident's service plan is developed or updated.

D. In addition to the medication requirements in R9-10-713, a licensee shall ensure that:
1. Assistance in the self-administration of medication or medication administration for a resident receiving personal care services is provided based upon a written medication order from the resident's primary care provider, medical practitioner, or as otherwise provided by law. A medication order includes:
   a. The name of resident;
   b. The name, strength, quantity, route of administration, and directions for the medication ordered;
   c. Precautionary statements, if applicable; and
   d. The signature of primary care provider or medical practitioner and date signed;
2. A verbal medication order from a primary care provider or medical practitioner is noted in a resident's medication record within 24 hours of receipt of the verbal order and a

supporting written order is obtained from the primary care provider or medical practitioner within 14 days of receipt of the verbal order. Only a manager or caregiver may receive a verbal medication order;

3. Only the following individuals provide medication administration:
   a. A representative or a resident's relatives;
   b. A nurse or other medical practitioner, or other individual authorized by law to provide medication administration; or
   c. An employee authorized in writing by a resident's physician;
4. A nurse, pharmacist, or primary care provider reviews the medication and medication record of each resident receiving medication administration or nursing services at least every 90 days and after a significant change in the resident's condition;
5. Employees and support staff do not provide non-prescription medication to a resident unless the resident has an order from the resident's primary care provider or medical practitioner for the medication; and
6. When a PRN medication is administered to a resident on a regular basis, the resident's primary care provider or medical practitioner is notified and a written order is obtained from the resident's primary care provider within 14 days.

E. A licensee of an assisted living facility licensed to provide personal care services shall ensure a treatment for a resident receiving personal care services is administered as follows:

1. A treatment that cannot be self-administered is administered by a nurse or as otherwise provided by law;
2. A treatment is administered according to a written order from the resident's primary care provider or medical practitioner. A treatment order shall include the:
   a. Name of resident;
   b. Name, route of administration, and directions for use of treatment ordered;
   c. Precautionary statements related to the administration of treatment, if applicable; and
   d. Signature of primary care provider or medical practitioner and date signed;
3. A verbal treatment order from a primary care provider or medical practitioner is noted in a resident's record within 24 hours of receipt of the verbal order and a supporting written order is obtained from the primary care provider or medical practitioner within 14 days of receipt of the verbal order. Only a manager or caregiver may receive a verbal treatment order; and
4. A written record of treatment administered to a resident is completed by an employee and includes the:
   a. Name of treatment, frequency, and route of administration;
   b. Date and time treatment is scheduled to be administered; and
   c. Date and time of actual treatment administration and signature or initials of the individual administering treatment.

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R9-10-723. Supplemental Requirements for an Assisted Living Facility Licensed to Provide Directed Care Services

A. A licensee shall ensure that a representative is designated for a resident who is unable to direct self-care.

B. A licensee of an assisted living facility licensed to provide directed care services shall not accept or retain a resident who:

1. Is bedbound, unless the requirements in R9-10-722(A)(3) are met;
2. Needs continuous nursing services, unless the requirements of R9-10-722(A)(2) are met; or
3. Has a stage 3 or stage 4 pressure sore as determined by a nurse or other medical practitioner unless the requirements in R9-10-722(A)(4) are met.

C. In addition to the ongoing training requirements in R9-10-707 (B) and R9-10-722(B), a licensee of an assisted living facility licensed to provide directed care services shall ensure each manager and caregiver completes a minimum of 4 hours of ongoing training in providing services to residents who are unable to direct self-care every 12 months from the starting date of employment, or for a manager or caregiver hired before the effective date of this Article, every 12 months from the effective date of this Article.

D. In addition to the supplemental service requirements in R9-10-722(C) a licensee of an assisted living facility providing services to a resident who is unable to direct self-care shall provide the following:

1. Direct supervision to ensure personal safety;
2. Coordination of communications with each representative, relatives, case manager, if applicable, and other individuals identified in the resident's service plan;
3. Cognitive stimulation and activities to maximize functioning;
4. Encouragement to eat meals and snacks;
5. An assessment of a resident who is unable to direct self-care by a primary care provider within 30 days of being accepted into the assisted living facility or within 30 days of becoming unable to direct self-care; and
6. Documentation of a resident's weight. A resident shall be weighed and the resident's weight recorded in the resident's service plan when a resident's service plan is developed or reviewed.

E. A licensee shall ensure that medication requirements in R9-10-722(D) are met for a resident receiving personal care services or directed care services.

F. A licensee shall ensure that treatments for a resident receiving personal care services or directed care services are administered as required in R9-10-722(E).

G. In addition to the requirements for a resident's record in R9-10-714, a licensee shall ensure that:

1. The resident record for a resident who is unable to direct self-care contains a record of services provided by a licensed home health agency or licensed hospice service agency including:
   a. A description of the home health service or hospice service provided to the resident and date and time provided;
   b. The name, address, and phone number of the home health agency or hospice agency; and
   c. Documentation of any instructions for the resident's care in the resident's service plan; and

2. Instructions for the resident's care are communicated to employees.

H. A licensee who provides services in a facility or portion of a facility to a resident who is unable to direct self-care shall:
1. Develop and implement policies and procedures that ensure the continued safety of a resident who may wander;
2. Ensure a means of exiting the facility that meets 1 of the following:
   a. The assisted living facility provides a resident who does not have a key, special knowledge for egress, or special physical effort, access at all times to an outside area that is secure and allows the resident to be at least 30 feet away from the facility. If the outside area does not allow a resident to be at least 30 feet away from the facility, the assisted living facility shall provide a means of egress from the outside area that allows the resident to be at least 30 feet from the facility; or
   b. The facility meets the Special Egress-Control Devices provisions in the Uniform Building Code incorporated by reference in A.A.C. R9-1-412.

I. A licensee shall follow notification requirements in R9-10-703(B)(12) each time a resident who is unable to direct self-care wanders off facility grounds.

Historical Note
Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on these rules (Supp. 98-4).

R9-10-724. Supplemental Requirements for Training Programs

A. A training program shall meet the following requirements:
1. Except as provided in subsection (A)(2), an instructor for the training program shall be any of following:
   a. A nurse, physician, physician assistant, or related medical professional with at least 2 years of health-related experience;
   b. An individual with at least a bachelors degree in social work, gerontology, or closely-related field and at least 2 years of health-related experience;
   c. An instructor employed by an accredited junior college, college, university or health care institution to teach health-related courses; or
   d. An assisted living facility manager with at least 2 years experience serving as a manager in a residential care institution;
2. If an instructor does not met the requirements in subsection (A)(1), the instructor may provide specific training in a level of training as designated in subsection (C)(3) or a training component as stated in subsection (B)(3) if the instructor has:
   a. Education that qualifies the instructor to provide the training;
   b. Experience that qualifies the instructor to provide the training; or
   c. Taught a class that includes the specific training;
3. An instructor for the training program shall not provide training if the instructor:
   a. Is serving as a manager of a health care institution operating under a provisional license; or
   b. Has had a license to operate a health care institution revoked or suspended;
4. Instructional methods for personal care services shall include opportunities for an individual receiving the training to practice skills on a mannequin or individual; and
5. Training shall be provided using the instructors, manuals, student handouts, learning objectives, and verification tools and methods approved by the Department as prescribed in subsection (D).

B. A training program shall:
1. Be constructed to allow an individual to demonstrate the specific skills and knowledge of a level of training or training component;
2. Issue a verification of completion of training:
   a. That states:
      i. The name of individual;
      ii. Each level of training completed by the individual;
      iii. The date of completion; and
      iv. The name of training program;
   b. To an individual who:
      i. Completes training in subsection (B)(3) and demonstrates specific skills and knowledge in the level of training; or
      ii. Does not complete the training in subsection (B)(3) but demonstrates the specific skills and knowledge in the learning objectives of the level of training;
3. Provide training as follows:
   a. For an individual who will be providing supervisory care services: 20 hours or the amount of time needed to verify that an individual demonstrates the specific skills and knowledge in the learning objectives in each of the following training components:
      i. Promoting resident dignity, independence, self-determination, privacy, choice, resident rights, and ethics;
      ii. Communicating effectively with a resident, a representative and relatives, individuals who appear angry, depressed, or unresponsive;
      iii. Managing personal stress;
      iv. Preventing abuse, neglect, and exploitation and reporting requirements;
      v. Controlling the spread of disease and infection;
      vi. Record keeping and documentation;
      vii. Following and implementing resident service plans;
      viii. Nutrition, hydration, and food services;
      ix. Assisting in the self-administration of medications;
      x. Developing and providing social, recreational, and rehabilitative activities; and
      xi. Fire, safety, and emergency procedures;
   b. For an individual who will be providing personal care services: In addition to verification of the training components in subsection (B)(3)(a), 30 hours or the amount of time needed to verify that an individual demonstrates specific skills and knowledge in the learning objectives of each of the following training components:

i. The aging process and medical conditions associated with aging or physical disabilities;
ii. Assisting residents in activities of daily living and taking vital signs; and
iii. Medications;

c. For an individual who will be providing directed care services: In addition to verification of the training components in subsection (B)(3)(a) and (b), 12 hours or the amount of time needed to verify that an individual demonstrates specific skills and knowledge in the learning objectives of each of the following training components:
i. Overview of Alzheimer's disease and related dementias;
ii. Communicating with a resident who is unable to direct self-care;
iii. Providing services, including problem solving, maximizing functioning, and life skills training for a resident who is unable to direct self-care;
iv. Managing difficult behaviors in a resident who is unable to direct self-care; and
v. Developing and providing social, recreational, and rehabilitative activities for residents who are unable to direct self-care;

d. For an individual who will be acting as a manager of an assisted living facility: 8 hours or the amount of time needed to verify that an individual demonstrates the specific skills and knowledge in the learning objectives in each of the following training components:
i. Developing resident service plans,
ii. Business practices,
iii. Personnel management,
iv. Delegation of authority,
v. Developing policies and procedures, and
vi. Overview of the laws and rules governing assisted living facilities;

4. Accept documentation that an individual is certified as a nursing assistant under A.R.S. Title 32, Chapter 15 as verification of the skills and knowledge required in subsection (B)(3)(b)(i) and (ii);
5. Use only instructors who meet the qualifications in subsection (A)(1) and (2);
6. Maintain the following records at the location designated on the application for 5 years from the date the instructor provided training:
a. The name and documentation of qualifications of each instructor;
b. A copy of each certificate of training issued by the training program;
c. The written instrument verifying that the individual demonstrated the specific skills and knowledge in each learning objective for a level of training; and
d. Evaluations required by subsection (B)(7); and
7. Ensure that an individual who receives a certificate of training submits an evaluation of the training program to the training program that includes:
a. The name of each instructor,
b. An evaluation of each instructor,
c. An evaluation of training, and
d. Suggestions or recommendations.

C. An applicant for Department approval of an assisted living training program shall submit an application to the Department that includes:
1. A completed application form, provided by the Department, that includes:
a. The name of the training program;
b. The mailing address for the training program;
c. The phone number for the training program;
d. The location or locations where training will be provided;
e. The location where training records will be maintained;
f. The name of a contact person; and
g. The signature of the following:
h. If an individual, the signature of the individual;
i. If a partnership, the signatures of 2 of the partners;
j. If a corporation, the signatures of 2 officers of the corporation;
k. If a limited liability company, the designated manager, or if no manager is designated, the signatures of any 2 members of the limited liability company; or
l. If a governmental agency, the signature of the director of the governmental agency or the individual designated in writing by the director.
2. The names and qualifications of each instructor providing training;
3. The designation of 1 or more of the following levels of training provided by the training program:
a. Supervisory care services;
b. Personal care services;
c. Directed care services; or
d. Manager training; and
4. The following information for each level of training provided:
a. The instructional method or methods;
b. A detailed training outline;
c. The learning objectives;
d. The instructor's manuals and student handouts; and
e. The tool and method or methods of verification that an individual has achieved the learning objective.

D. For Department approval of a training program:
1. The overall time-frame described in A.R.S. § 41-1072(2), is 90 days.
2. The administrative completeness review described in A.R.S. § 41-1072(1) is 60 days and begins on the date the Department receives an application.
a. If any of the documents is missing or if information on the documents is deficient, the Department shall provide to the applicant a written notice of incompleteness that states each deficiency and the information or documents needed to complete the application. The 60 day time-frame for the Department to finish the administrative completeness review is suspended from the date the Department provides the notice of incompleteness to the applicant until the date the Department receives the required information or missing document.
b. If all of the documents are submitted and the information on the documents is complete, the Department shall provide a written notice of administrative completeness to the applicant.
c. If the documents or information are not submitted within 120 days from the date of notice of incompleteness, the Department shall consider the application withdrawn.
d. If the Department grants approval to the training program during the time provided to assess administrative completeness, the Department shall not provide a separate written notice of administrative completeness.

3. The substantive review time-frame described in A.R.S. § 41-1072(3) is 30 days and begins on the date the Department provides written notice of administrative completeness to the applicant.
   a. If the applicant does not meet the requirements of this Section the Department shall provide a written request for additional information to the applicant. The 30 day time-frame for the Department to finish the substantive review is suspended from the date the Department provides the written request to the applicant until the Department receives the additional information.
   b. The applicant shall submit to the Department the information or documents identified in the written request for additional information within 30 days of the receipt of the written request.
   c. The Department shall provide the applicant with a written notice of denial if:
      i. The applicant does not submit the additional information within the time-frame in subsection (D)(3)(b); or
      ii. Upon receipt of the additional information from the applicant, the Department determines that the applicant does not meet the requirements of this Section.
   d. An applicant may appeal the Department's determination according to A.R.S. Title 41, Chapter 6.
4. If an applicant meets the requirements of this Section, the Department shall provide a written notice of Department approval to the applicant.

E. To change the level of training that a training program is approved to provide, the training program shall submit to the Department the information for the requested level of training in subsection (C)(2),(3), and (4). The Department shall comply with the requirements for approval of a training program in subsection (D).

F. A training program shall not provide training or a level of training until the training program receives written Department approval.

G. A training program shall submit to the Department:
1. Any changes to the information required in subsection (C)(1) no later than 30 days from the date of the change, and
2. The information required in subsection (C)(2) for an instructor before the instructor provides training for the training program.

H. To renew a training program's approval, a training program shall submit to the Department every 24 months from the date of approval, the information in subsection (C). The Department shall comply with the requirements for approval of a training program in subsection (D).

I. The Department may withdraw a training program's approval if:
1. The training program does not comply with the requirements in subsection (A),(B), or (C);
2. The Department determines that the training program issued a certificate of training to an individual who did not demonstrate the specific knowledge and skills of a learning objective in a training component in the level of training stated on the certificate; or
3. The training program fails to meet the requirements in subsection (E), (F), (G), or (H).

J. The Department may observe a training program's instructional or verification methods; review the training programs records; and interview instructors, individuals trained, and other individuals to determine a training program's compliance with this Section.

Historical Note
Adopted effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

ARTICLE 8. HOSPICES

R9-10-801. Definitions

In this Article, unless the context otherwise requires:
1. "Bereavement services" means social and emotional support offered to the family for at least 1 year following the death of a patient.
2. "Family" means a hospice patient's immediate family consisting of a spouse, sibling, child, parent and/or those individuals designated as caregivers by the patient.
3. "Home health aide services" means the performance of simple procedures as an extension of therapy services, personal care, ambulation and exercise, and household services essential to health care at home.
4. "Hospice care team" means a physician, a registered nurse, a counselor, and volunteers.
5. "Hospice respite services" means care provided to the patient when necessary to relieve the family caring for the patient. The care may be provided in the patient's residence or an inpatient facility.
6. "Hospice service plan" means a detailed plan which identifies the services offered by the hospice and the staff who will provide the services.
7. "Inpatient services" means hospice services provided to a patient in a hospital, nursing care institution or other facility which meets the requirements of this Article.
8. "Patient" means a terminally ill person receiving hospice services.
9. "Research" means the use of human subjects in the systematic study, observation or evaluation of factors related to the prevention, assessment, treatment, and understanding of an illness.
10. "Staff" means employees and volunteers of a hospice.
11. "Terminally ill" means a medical diagnosis by a physician that a person has a specific, progressive, normally irreversible disease which will cause the person's death in the foreseeable future.
12. "Volunteer" means a person who provides services to a hospice without compensation.

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R9-10-802. General requirements

A. No agency or organization shall establish, conduct or maintain a hospice without first obtaining a license from the Department.

B. Application for licensure as a hospice shall be made on forms provided by the Department.

C. The hospice service plan shall be submitted with the licensure application and shall contain:
1. The name of the governing authority and the person responsible for administering the hospice,
2. The estimated average monthly patient census,
3. The proposed geographic area to be served by the hospice,
4. A listing of services provided by the staff of the hospice and those services provided through contractual agreement,
5. The names and qualifications of persons or entities under contract to provide hospice services,
6. The names and qualifications of the hospice care team,
7. A description of how the hospice will utilize volunteers,
8. A description of the hospice's recordkeeping system, and
9. The current annual operating or proposed budget.

D. The license shall not be transferable to a new location or a new owner and shall be the property of the Department. The license shall be returned to the Department immediately upon suspension or revocation of the license or upon termination of the hospice by the licensee.

E. A hospice shall submit a new application for a change of ownership. A new application shall also be submitted when there is a change of location of the inpatient facility which is specified on the license. A hospice shall not be operated at the new location or under new ownership prior to the issuance of a new license for such location or owner. Hospice services which are to be provided at locations other than at the inpatient facility specified on the license shall give 30-days notice prior to a change in location of the agency or organization.

F. The licensee shall notify the Department, in writing, at least 30 days prior to any change in:
1. Contracts with providers of hospice services,
2. Geographic service area, or
3. Hospice services.

G. The Department shall be notified at least 14 days prior to a change of Administrator.

H. A license shall be valid for a period of 1 year. The hospice shall submit an application for renewal on a form provided by the Department which is delivered to the Department in a manner which documents receipt by the Department at least 90 days prior to expiration of the existing license.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4).

R9-10-803. Administration

A. Each hospice shall be organized and administered under 1 governing authority. The governing authority shall be ultimately responsible for the agency, establishing its policies and overseeing its operation.

B. An advisory board shall be appointed. The members of the advisory board shall:
1. Reside in the geographic service area defined in the hospice service plan;
2. Have no direct or indirect financial interest in the hospice;
3. Assist in adopting, annually reviewing and revising, as necessary, the written philosophy, policies and procedures for operation and administration of the hospice; and
4. Meet at least annually.

C. The governing authority shall appoint an administrator who shall either be:
1. A physician;
2. A registered nurse with a baccalaureate degree in nursing and at least 1 year of administrative or supervisory experience in community health programs; or
3. A person with a baccalaureate degree in human services or administration and at least 1 year of administrative or supervisory experience in community health programs, or a person with five years of administrative supervisory experience with at least 1 year experience in community health programs.

D. The administrator shall:
1. Be responsible for the daily administration, supervision, maintenance and operation of the hospice;
2. Designate, in writing, a qualified person, to act as administrator for those periods when the administrator is absent. If the administrator is absent for more than 30 continuous days, the designee shall have the qualifications prescribed by these rules for an administrator.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4).

R9-10-804. Medical advisor

A. Each hospice shall have a medical advisor who is a physician and who shall have overall responsibility for the medical component of the hospice.

B. The duties of the medical advisor shall be to:
1. Serve as a consultant to the hospice care team;
2. Assist in the development and review of patient and family care policies and procedures; and
3. Serve as a resource to the patient's attending physician.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4).

R9-10-805. Policies and procedures

A. Each hospice shall have written policies and procedures governing the following:
1. Personnel policies;
   a. The policies and procedures governing personnel matters shall require:
      i. Verification that personnel are free from current pulmonary tuberculosis. Documentation shall include 1 of the following:
         (1) Report of a negative Mantoux skin test within a year prior to date of employment or acceptance as a volunteer,
         (2) Physician's report of a negative chest x-ray,
         (3) Report of an annual skin test indicating continuance of negative status, or
         (4) A physician's statement provided each year noting that there is no symptomatic evidence of current pulmonary tuberculosis disease.
      ii. Orientation, training, and continuing education requirements;
      iii. Job descriptions and provisions for annual review and revision; and
      iv. Confidentiality of personnel records.
   b. Personnel records shall be maintained for all staff and shall contain:
      i. A copy of a staff member's license or certificate, as applicable;
      ii. Completed application form; and
      iii. Job description.
2. Volunteer services;
   a. The policies and procedures for volunteers shall contain:
      i. The philosophy, objectives and scope of the volunteer program;
      ii. Qualifications for volunteers;
      iii. The duties of the volunteers; and
      iv. A written plan to orient volunteers to their duties.
   b. Volunteer personnel records shall be maintained and shall contain:
      i. Documentation of completion of a training program, certified by the Arizona Hospice Organization, for volunteers who provide direct patient care;
      ii. Completed volunteer application form;
      iii. Duties of the volunteer; and
      iv. Record of assignments and work hours.
3. Patient rights; Each hospice shall establish a written policy regarding the rights and responsibilities of patients and develop procedures for the implementation of such policies. Each patient and family shall:
   a. Be treated with consideration, respect and full recognition of his dignity and individuality;
   b. Receive individualized treatment;
   c. Be provided adequate and humane services;
   d. Be assured personal privacy, including right not to be photographed without written consent;
   e. Be assured confidential handling of personal and medical records;
   f. Be informed of charges for services provided by the hospice program; and
   g. Have the right to refuse to participate in experimental research;
4. Admissions;
5. Hospice services offered; and
6. Inpatient services.

B. A hospice which conducts research shall have written policies and procedures which shall provide for:
1. Written, informed consent of each participant;
2. Protocols for conducting the research;
3. Establishment of an interdisciplinary committee to review and approve research;
4. Confidentiality of participant's identity; and
5. Methods for disclosure of research data.

C. The policies and procedures shall be:
1. Annually reviewed and, if necessary, revised; and
2. Available to staff, patients, families and the public.

Historical Note

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R9-10-806. Admissions

A. Admission to a hospice shall be limited to individuals who have been diagnosed by their attending physician as terminally ill.

B. Upon admission, each patient shall be oriented to the hospice's philosophy, policies, procedures, services, and patient rights. Each patient shall be provided a written copy of the patient rights. A written copy of the philosophy, policies, procedures, and services shall be provided upon request.

C. Each patient admitted to a hospice shall have an attending physician.

D. An assessment of the patient's medical, social, and psychological needs shall be made upon admission.

Historical Note

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R9-10-807. Patient care plan

A. A written care plan based upon the assessment of the patient's needs shall be prepared by the hospice care team upon admission of each patient. The patient and family shall be involved in preparing the care plan.

B. Each care plan shall be reviewed by the hospice care team at least monthly.

C. The care plan shall contain:
1. A complete assessment of the patient's care needs,
2. Identification of appropriate living arrangements, and

3. Types and frequency of prescribed therapy to be administered.

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R9-10-808. Hospice services

A. Hospice services shall include nursing services, respite services, volunteer and bereavement services. Each hospice shall:
1. Provide services either directly or by written contractual agreements with other providers or through the use of community resources;
2. Maintain administrative control and responsibility for the provision of all services;
3. Be responsible for ensuring that all services are provided in accordance with the patient's care plan;
4. Be available on call to patients and/or families 24 hours a day, seven days a week; and
5. Have a registered nurse on staff who shall serve as coordinator of the hospice care team. The registered nurse shall be responsible for assessment of the patient, follow-up visits with the patient, development and implementation of the therapeutic plan as prescribed by the physician and supervision of nursing care provided to the patient.

B. Hospice services may include social services, counseling services, dietary services, homemaker services, home health aide services, habilitation services and inpatient services.

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R9-10-809. Clinical record

A. A clinical record shall be established and maintained for each patient receiving hospice services.

B. The clinical record shall contain:
1. Identification data,
2. Consent and authorization forms,
3. Pertinent medical history,
4. Physician orders,
5. Initial and subsequent assessments,
6. Plan of care, and
7. Documentation of all services provided.

C. Records shall be safeguarded against loss, destruction and unauthorized use.

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R9-10-810. Quality assurance

A. Each hospice shall establish a written quality assurance plan.

B. The quality assurance plan shall provide for an ongoing assessment of the quality and appropriateness of care provided.

C. The hospice shall use the findings to correct identified problems and to revise hospice policies, if necessary.

D. Documentation shall be maintained showing evidence that the findings and means of correcting problems were reviewed by the governing authority.

Historical Note
Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted effective October 30, 1989 (Supp. 89-4).

R9-10-811. Inpatient services requirements

A. General
1. A hospice providing inpatient services shall comply with all applicable federal, state and local laws, rules, and codes pertaining to physical plant, health, and safety.
2. Twenty-four hour nursing services, which are sufficient to meet total nursing needs and which are in accordance with the patient care plan, shall be provided. Each patient shall receive treatments, medications and diet as prescribed and shall be kept comfortable, clean, well-groomed and protected from accident, injury and infection.
3. There shall be at least 1 registered nurse on each tour of duty to supervise direct patient care.
4. The visitation policy shall provide for visiting hours which are flexible and shall include visitation by infants, children, and pets.

B. Pharmaceutical services
1. Administration of medications
   a. Self-administration of medications by patients is not permitted unless ordered by the patient's physician or performed in a predischarge training program under the supervision of a licensed nurse.
   b. Adverse drug reactions shall be reported by a licensed nurse immediately to the attending physician and an entry shall be made in the patient's medical record.
   c. Medication errors shall be reported to the attending physician and an incident report prepared.

d. Medications shall be administered only by a licensed nurse or physician.
e. Drugs and/or biologicals shall be administered as soon as possible after the dose is prepared by the same licensed nurse who prepared the dose for administration, except that a physician may administer a drug that has been prepared at his direction by a licensed nurse.

2. Storage and disposition of medications
a. Except for unit dosages, each patient's medications shall be stored in original prescription containers in a separate storage space reserved for each patient.
b. A record shall be maintained which lists on a separate sheet for each type of controlled drug the date and quantity received, signature of nurse accepting delivery, date and time of administration, name of patient, dose, physician's name, signature of person administering the dose, and the balance of drug remaining.
c. All medications shall be kept under secure conditions such as in a locked drug room or cabinet.
d. Medications requiring refrigeration shall be kept in a separate locked box which is securely fastened within the refrigerator, unless the refrigerator is locked or is located in a locked drug room. Temperature of the refrigerator shall not exceed 45°F.
e. Medications for external use, and eye, ear, and rectal medications shall be kept separate from other medications.
f. Medications which have exceeded their expiration dates, those which are unusable or which are not to be released to the patient upon discharge and those which have an illegible or missing label shall be separated from other medications and disposed of by a pharmacist. If medications are destroyed by a pharmacist who is not an employee of the Arizona State Board of Pharmacy, the administrator or his designee shall witness the destruction.

C. Nutrition services
1. A registered dietitian or a food service supervisor under the direction of a registered dietitian shall:
a. Assess the nutritional status and needs of the patients; and
b. Assist in the development, implementation and evaluation of the patient care plan.

2. Planning of menus and food supplies
a. Menus shall be planned to meet the nutritional needs of patients in accordance with physician's orders.
b. The meals for each day shall contain:
i. Four servings of fruits and vegetables;
ii. Four servings of whole grain or enriched cereals and breads;
iii. Two servings of milk or dairy products; and
iv. Two servings of protein: meat, fish, poultry, cheese, egg, peanut butter, peas, beans, lentils, or equivalent.
c. At least 1 serving of at least 1 of the following four food components shall be offered at the first snack of the day, and at least 1 serving each of at least two of the following four food components shall be offered for the bedtime snack:
i. Fruit and/or vegetable or full-strength fruit or vegetable juice;
ii. Whole grain or enriched cereal or bread;
iii. Milk or other dairy product; and
iv. Meat, fish, poultry, cheese, egg, or peanut butter.
d. When a therapeutic diet is prescribed for the patient, snacks provided shall comply with the diet prescription.
e. Menus and snacks shall be planned at least 1 week in advance.

3. Food shall be prepared by methods that conserve nutritive value, flavor, and appearance and shall correspond with the items on the menu.

D. Sanitation and infection control
1. The facility shall be kept clean, safe and free from hazards, offensive odors, accumulations of dirt, miscellaneous debris, dust, lint, discarded equipment, and materials.
2. Written procedures shall be established to prevent the transmission of infection. The procedures shall provide for:
a. Investigation, control and prevention of infections in the facility;
b. Aseptic and isolation techniques to be followed by all personnel; and
c. Daily environmental cleaning procedures, including type of cleaning material and equipment, to be used.
3. Contaminated dressings and other similar materials shall be disposed of in a sanitary landfill approved by the Department of Environmental Quality. Where such an approved sanitary landfill is not available, contaminated wastes shall be disposed of by incineration facilities approved by the county air quality control agency. In those counties which have no county air quality control agency, the incineration facilities shall meet the standards of the Arizona Department of Environmental Quality.
4. Bedpans, urinals, emesis basins, wash basins, and other personal nursing items shall be thoroughly cleaned after each use and sanitized. All such equipment shall not be used if chipped or otherwise damaged.
5. All catheters, irrigation sets, drainage tubes or other supplies or equipment for internal use which cannot be autoclaved or otherwise sterilized shall be used only once and discarded.
6. Each lavatory in the facility shall have a soap dispenser and a dispenser with disposable paper towels or a hand drying device.
7. Tubs, portable commodes, showers and shower chairs shall be thoroughly cleaned after each patient's use.
8. Linens shall be handled, stored, processed and transported in such a manner as to prevent the spread of infection.
9. Staff shall wash their hands immediately after providing personal or nursing care to each patient.

E. Physical requirements
1. The inpatient facility shall be maintained in good repair.
2. The temperature in the patient care areas shall be maintained between 70 - 82° F.
3. Patient care areas shall be designated and equipped for the comfort and privacy of each patient and family members.
4. The inpatient facility shall have:
a. Designated space for private patient and family visits;
b. Accommodations for family members to remain with the patient throughout the night;
c. Accommodations for family privacy after a patient's death;
d. Decor which is homelike in design and function; and

e. Patient rooms which shall:
   i. Be equipped with, or conveniently located near, toilet and bathing facilities;
   ii. Be at or above ground level;
   iii. Contain a bed, bedside table, bedside chair, and reading light for each patient;
   iv. Have closet space that provides security and privacy for clothing and personal belongings;
   v. Be clean and well ventilated;
   vi. Contain no more than four beds;
   vii. Measure at least 100 square feet for a single patient room or 80 square feet for each patient for a multi-patient room; and
   viii. Be equipped with an audio-visual system for calling the staff member on duty.

F. Disaster preparedness
1. There shall be a current written plan of operation with procedures to be followed in the event of fire, explosion or other disaster or threat to patient safety. The plan shall:
   a. Contain procedures for prompt transportation of patients and records, instructions regarding the location and use of alarm systems and fire-fighting equipment, information regarding methods of containing fires, procedures for notification of the appropriate persons and agencies and specifications, routes, and procedures for evacuation.
   b. Designate the specific place to which patients may be evacuated, and the detailed arrangements to provide adequate shelter, beds, food and water, and nursing care, including medications and other services critical to the well-being of patients who must be moved.
2. Employees shall be oriented to disaster preparedness within the first week of employment. If an employee has not received such orientation, the employee shall not be permitted to be the only employee in the facility until such orientation is completed. The disaster program shall include ongoing training and a drill for disaster other than fire, at least semiannually, for personnel so that each employee can promptly and correctly perform specific duties in case of disaster.
3. There shall be at least 1 fire drill per shift during each calendar quarter.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4).

R9-10-812. Variances

A. A hospice may submit to the Department a written request for a variance from any rule in this Article, accompanied by documentation justifying the proposed alternative means of meeting the requirements which shall not adversely affect the health and safety of its patients.

B. An approved variance shall be for a period not to exceed 1 year and may be renewed upon reapplication with documented justification. Reapplication shall be made at least 60 days prior to the expiration of the current variance.

Historical Note

Adopted as an emergency effective October 26, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Readopted without change as an emergency effective January 27, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective April 27, 1989 (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective July 31, 1989 (Supp. 89-3). Permanent rules adopted with changes effective October 30, 1989 (Supp. 89-4).

ARTICLE 9. NURSING CARE INSTITUTIONS

R9-10-901. Definitions

In this Article, unless the context otherwise requires:
1. "Abuse" means the same as defined in A.R.S. § 46-451(A)(1) and includes corporal punishment, involuntary seclusion, and mental, physical, sexual, and verbal abuse.
2. "Accident" means an unexpected occurrence that causes harm to a resident.
3. "Activities of daily living" means ambulating, bathing, toileting, shaving, brushing teeth, combing hair, dressing, eating, getting in or out of a bed or chair, cleaning the resident's room, laundering, shopping, using public transportation, writing letters, communicating, making telephone calls, obtaining appointments, recreation, and leisure activities.
4. "Administrator" means the same as defined in A.R.S. Title 36, Chapter 4, Article 6.
5. "Advance directive" means a written expression of a resident's wishes relating to the provision of health care when the resident is incapacitated and includes a living will, prehospital medical care directive, or health care power of attorney.
6. "Biologicals" mean medicinal compounds that include serums, vaccines, antigens, and antitoxins prepared from living organisms and their products.
7. "Care plan" means a written program of action for each resident which includes measurable objectives and timetables for meeting a resident's physical, medical, nursing, mental, and psychosocial needs that have been identified in the resident's assessment.
8. "Chemical restraint" means a psychopharmacologic drug that is used for discipline or convenience and is not required to treat a resident's medical symptoms.
9. "Cognitive status" means an individual's level of awareness with perception, reasoning, judgment, intuition, and memory.
10. "Corporal punishment" means the infliction of a physical penalty causing suffering, pain, or loss that serves as retribution.
11. "Disaster" means an unforeseen event, including a flood or fire, which may result in a facility, or a portion thereof, becoming uninhabitable and which necessitates evacuation of residents to another location.
12. "Hospital-based nursing care institution" means a department, division, or unit of a licensed hospital that provides nursing and health-related services within the hospital, on a contiguous portion of the hospital's campus, or not more than 300 yards from the hospital to allow the coordination of services.

13. "Interdisciplinary team" means a group consisting of the attending physician, a registered nurse responsible for the resident, and other appropriate staff as determined by the resident's needs.
14. "Involuntary seclusion" means the separation of a resident from other residents against the will of the resident or the resident's representative unless the separation is necessary in treating the resident's medical symptoms.
15. "Licensed nurse" means an individual licensed pursuant to A.R.S. Title 32, Chapter 15.
16. "Medical director" means a physician licensed pursuant to A.R.S. Title 32, Chapters 13 and 17.
17. "Medication" means any drug or medicine used in the maintenance of health and prevention or treatment of disease and illness.
18. "Medication error" means any of the following:
    a. A medication ordered but not administered and the omission not recorded,
    b. The wrong medication administered, or
    c. A medication administered:
        i. In the wrong dosage,
        ii. More than 60 minutes from the ordered time of administration,
        iii. By the wrong route of administration, or
        iv. To the wrong resident.
19. "Mental abuse" means humiliation, harassment, threats of punishment, or deprivation.
20. "Neglect" means the lack of supervision, failure to provide care or services necessary to ensure the health, safety and well-being of a resident, failure to determine what care or services are necessary for the well-being of a resident or failure to provide a safe and sanitary environment.
21. "Physical abuse" means beating, inflicting physical pain or causing injury to a resident, or endangering a resident's health or well-being, including withholding food or medical care.
22. "Physical restraint" means confinement in a locked room or the use of any article, device, or garment that interferes with freedom of movement, that cannot be easily removed by the resident, or that is used to control the resident's behavior.
23. "Resident" means an individual admitted into a facility and includes any person who is receiving respite care services.
24. "Resident group" means a number of individuals who reside in a facility and meet to discuss issues related to facility operation.
25. "Resident's representative" means a person acting on behalf of a resident with the written consent of the resident or resident's legal guardian.
26. "Significant change in condition" means a deterioration in health, mental, or psychosocial status in either life-threatening circumstances or clinical complications.
27. "Significant medication error" means the administration of medications, or omission thereof, which causes the resident severe discomfort or jeopardizes a resident's health and safety.
28. "Treatment" means medical, surgical, dental, or psychiatric management of a resident, and any specific procedure used for the prevention, cure, or amelioration of a disease or pathological condition.
29. "Unnecessary drug" means medication that is used:
    a. When there is no indication for its use;
    b. In excessive dose, including duplicate therapy;
    c. Without adequate monitoring to assess the effectiveness of the medication; or
    d. Under adverse consequences that indicate the dose should be reduced or discontinued.
30. "Verbal abuse" means any use of disparaging or derogatory comments that describe residents or their relatives, regardless of the resident's age, disability, or ability to comprehend.

Historical Note
Adopted effective February 17, 1995 (Supp. 95-1).

R9-10-902. Administration

A. Each facility shall have a governing authority responsible for the organization and administration of the facility. The governing authority shall:
1. Ensure facility compliance with state laws, rules and local ordinances;
2. Adopt policies and procedures for the facility;
3. Appoint an administrator to manage the facility. The administrator shall be appointed in accordance with 1 of the following:
    a. By the governing authority of the facility;
    b. By a hospital governing authority to serve a dual role, as follows:
        i. For both the hospital and a hospital-based nursing care institution whose bed capacity does not exceed 60; or
        ii. Two hospital-based nursing care institutions, provided 1 of the facilities operates within the hospital and its bed capacity does not exceed 60;
    c. By the governing authority of two or more facilities to manage no more than two of the facilities under the following conditions:
        i. The distance between the two facilities does not exceed 40 miles, and
        ii. Neither facility is operating under a provisional license;
4. Appoint another administrator when the administrator is absent for 30 consecutive days; and
5. Notify the Department, in writing, of the following:
    a. The name and license number of a newly-appointed administrator within five working days after the effective date of change;
    b. A change of ownership not less than 30 days prior to the change; and
    c. The location and arrangements for the maintenance of records not less than 30 days prior to the cessation of facility operations

B. The administrator shall report to the governing authority and shall be responsible for the following:
1. Staffing, which shall include the following:
    a. Appointing a medical director to be responsible for resident medical care in the facility, which shall include: Overseeing physician practices, including any physician-delegated tasks to a physician assistant or nurse practitioner pursuant to A.R.S. Title 32, Chapters 15 and 25;
        ii. Providing supervision of the clinical care of residents; and
        iii. Monitoring and evaluating health care and treatment and taking corrective action for related problems;
    b. Appointing a registered nurse to serve as a full-time director of nursing;

c. Appointing a social services director to develop and conduct a social services program; and
d. Appointing an activities director to develop and conduct an activities program;
2. Supervising and evaluating staff performance;
3. Developing and implementing written policies and procedures for the following:
a. Resident rights,
b. Nursing services,
c. Advance directives,
d. Personnel,
e. Orientation and inservice training,
f. Admission and discharge,
g. Safety and emergency plan,
h. Infection control,
i. Quality management plan,
j. Maintenance of residents' personal accounts, and
k. Residents' petty cash fund;
4. Designating, in writing, an individual who shall be on duty, in charge, and have access to all areas within the facility and grounds that are related to resident care and operation of the facility when the administrator is absent;
5. Notifying, in writing, each resident or resident's representative of any change in rates or services 60 days prior to the change;
6. Ensuring the safe and orderly transfer of residents and their clinical records if the facility ceases operation;
7. Ensuring that all facility records are transferred to the new owner in the event of a change in ownership;
8. Investigating and reporting all allegations involving resident neglect, abuse, or misappropriation of resident property to the Office of Long-Term Care Licensure and Adult Protective Services, if required by A.R.S. § 46-454, and preventing further neglect, abuse, or misappropriation of property while the investigation is in progress;
9. Reporting to the Arizona State Board of Nursing, Nurse Aide Registry, or appropriate licensing board any knowledge of a criminal conviction of a nurse aide or a licensed professional;
10. Investigating and reporting to the Office of Long-Term Care Licensure any injuries of an unknown source which may require physician intervention and any disaster or unusual occurrence of the severity that poses a threat to the health and safety of residents;
11. Designating a staff person to act as a resident advocate to assist and act upon requests and recommendations from residents or resident and family groups, and to respond, in writing, to grievances and complaints that are submitted;
12. Posting in a conspicuous area, the following documents:
a. Operating permits, licenses, and certificates;
b. Names, addresses, and telephone numbers of the Office of Long-Term Care Licensure, the State Long-Term Care Ombudsman Program, and Adult Protective Services;
c. A statement that the resident may file a complaint with the Office of Long-Term Care Licensure regarding any area of facility operation;
d. The results of the most recent survey of the facility and any plan of correction in effect, or a notice of its availability and location, seven days a week, in a place that is readily accessible to residents; and
13. Ensuring the maintenance of the following:
a. Schedules of rates and charges;
b. Policies and procedures;
c. Staffing records for the preceding six months;
d. Current fire inspection and sanitation reports;
e. Records of fire and disaster drills for the preceding licensure period;
f. Orientation and inservice program records;
g. Job descriptions which define qualifications, duties, and responsibilities; and
h. Personnel and resident records.

C. The administrator may accept, upon request of a resident or resident's representative, responsibility for managing a personal account for a resident. If the administrator accepts the responsibility, the administrator shall ensure the following:
1. A system is maintained with complete and separate accounting of each resident's personal account;
2. A person is designated to be responsible for managing residents' personal accounts;
3. A written authorization for expenditures is given by each resident;
4. A resident's personal funds in excess of $50 are deposited in an interest-bearing account and that all interest earned on the resident's funds is credited toward that account;
5. A separate account record is maintained for each resident who authorizes expenditures;
6. Records are maintained on all receipts and expenditures of the personal account;
7. There is no commingling of residents' accounts with facility accounts;
8. Each resident or resident's representative shall be given a written statement of the financial transactions made on the resident's behalf, every calendar quarter, and upon request by the resident or resident's representative; and
9. Upon the death of a resident, the facility shall convey the resident's monies and a final accounting of those monies to the individual or probate jurisdiction administering the resident's estate within 30 days.

D. The administrator may establish a petty cash fund for use by residents during normal business hours, in accordance with the facility's petty cash fund policy and procedures which shall include:
1. Prescribed cash limits of the petty cash fund;
2. Internal procedures for use of the fund; and
3. Written acknowledgment, by the resident, of each petty cash transaction.

Historical Note
Adopted effective February 17, 1995 (Supp. 95-1).

R9-10-903. Personnel

A. An employee, at the time of employment and annually thereafter, shall submit 1 of the following as evidence of being free from pulmonary tuberculosis:
1. A report of a negative Mantoux skin test taken within three months of submitting the report; or
2. A written physician's statement indicating freedom from tuberculosis, if the individual has had a positive skin test for tuberculosis.

B. The administrator shall ensure that orientation for personnel is provided within the first week of employment which shall include:
1. Policies and procedures;
2. Resident rights and facility rules;
3. Basic infection control techniques, including hand washing, linen handling, and prevention of communicable diseases; and
4. Fire, disaster, and emergency preparedness.

C. The administrator shall ensure that personnel who provide direct care to residents shall be 18 years of age or older and shall attend 12 hours of inservice education annually which may include time spent in orientation.

D. The administrator shall ensure that a personnel record for each employee is maintained on the premises and shall include the following:
1. Application for employment;
2. Verification of training, certification or licensure;
3. Initial proof of freedom from tuberculosis and annual verification statement thereafter; and
4. Orientation records.

E. The administrator shall ensure that inservice records are maintained on each employee which shall include:
1. Date of inservice,
2. Class content,
3. Length of inservice,
4. Instructor's name, and
5. Signatures of those in attendance.

Historical Note
Adopted effective February 17, 1995 (Supp. 95-1).

R9-10-904. Staffing

A. The administrator shall ensure that personnel provide the following:
1. Nursing services,
2. Nutritional services,
3. Activities program,
4. Social services,
5. Housekeeping services, and
6. Maintenance.

B. The administrator for a hospital-based nursing care institution and an affiliated hospital may designate personnel to jointly provide services in each facility unless this is expressly prohibited by federal or state law. Staff time spent in each facility shall be documented.

Historical Note
Adopted effective February 17, 1995 (Supp. 95-1).

R9-10-905. Nursing Services

A. The director of nursing shall be responsible for the management and supervision of nursing services which shall include:
1. Developing and implementing written nursing policies and procedures for:
   a. Resident care, and
   b. Medications, including administration, storage, and disposal;
2. Participating in quality management activities;
3. Appointing, in writing, a registered nurse to act in the absence of the director of nursing;
4. Designating a licensed nurse to serve as a charge nurse on each shift who shall have overall supervisory authority for the provision of nursing services to no more than 64 residents during each shift;
5. Serving as a charge nurse only when a facility has an average daily occupancy of 60 or fewer residents;
6. Ensuring that the facility is staffed with nursing personnel to provide each resident the care and services identified in the resident's assessment and care plan; and
7. Maintaining daily staffing records for the past six months which include the census on each unit, name and license of each individual, and actual hours worked.

B. A registered nurse shall complete an assessment of each resident's needs that describes the resident's capability to perform activities of daily living and significant impairments in functional capacity. The assessment shall include the following information:
1. Medically defined conditions and prior medical history;
2. Medical status measurement, including information on vital signs, clinical laboratory values, or diagnostic tests;
3. Physical functional status;
4. Sensory and physical impairments;
5. Nutritional status and requirements;
6. Special treatments or procedures;
7. Mental and psychosocial status;
8. Discharge potential;
9. Dental condition;
10. Activities potential;
11. Rehabilitation potential;
12. Cognitive status; and
13. Medications.

C. Assessments shall be completed:
1. Within 14 days of admission,
2. After a significant change in the resident's physical or mental condition, and
3. Twelve months from the last complete assessment.

D. A registered nurse shall review the resident's assessment every three months and, if significant changes in the resident's health status have occurred, shall revise the assessment and the care plan.

E. An interdisciplinary team, in conjunction with the resident or resident's representative to the extent possible, shall develop a care plan within seven days after the completion of a resident's assessment which shall:
1. Be based on the resident's assessment;
2. Have measurable objectives and timetables to meet the resident's needs that are identified in the assessment; and
3. Specify the care and services necessary for the resident to maintain the highest practicable physical, mental, and psychosocial well-being.

Historical Note
Adopted effective February 17, 1995 (Supp. 95-1).

R9-10-906. Resident Rights

A. The administrator shall ensure that each resident or resident's representative is given a list of resident rights and a copy of the facility rules at the time of admission. Receipt of the documents shall be acknowledged in writing by the recipient and kept in the resident's current clinical record.

B. The administrator and staff shall ensure that language barriers or physical disabilities do not prevent a resident or resident's representative from being aware of facility rules governing resident conduct and the following resident rights:
1. To be free from:
   a. Chemical and physical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms;
   b. Verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion; and
   c. Interference, coercion, discrimination, and reprisal from the facility in exercising the resident's rights; and
2. To be treated with respect and dignity in full recognition of the resident's individuality;
3. To receive services in the facility which accommodate, within reason, the individual needs and preference of the resident;
4. To independently manage personal financial affairs;
5. To be fully informed of the resident's total health status, including the resident's medical conditions;
6. To choose a personal physician, unless a resident's insurance or pay source dictates otherwise, at which time, a resident may choose to assume full financial responsibility for selection of a physician of the resident's choice and to be informed of the name and method of contacting the physician responsible for the resident's care;

7. To participate in planning or changes in care and treatment, unless the resident is incapacitated under state law;
8. To personal privacy in accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family or resident groups;
9. To submit grievances to facility staff and outside representatives without restraint;
10. To examine the results of the most recent survey of the facility and any plan of correction in effect;
11. To receive information from agencies acting as client advocates and to be allowed the opportunity to contact these agencies;
12. To be informed of the facility's policy regarding the implementation of advance directives;
13. To refuse treatment which includes the formulating of an advance directive or withdraw consent for treatment;
14. To refuse to participate in experimental research;
15. To perform or refuse to perform services for the facility;
16. To have immediate access to, and communication with, any individuals, organizations, or agencies the resident desires;
17. To choose activities, schedules, and health care consistent with the resident's interests and assessment;
18. To organize and participate in resident and family groups within the facility;
19. To participate in social, religious, political, and community activities that do not interfere with the rights of other residents in the facility;
20. To retain and use personal possessions, including furnishings and clothing as space permits, unless it infringes on the rights or health and safety of other residents;
21. To share a room with the resident's spouse, if space is available, providing both spouses consent to the arrangement;
22. To have access to all records pertaining to the resident, including clinical records, within 24 hours of making a request;
23. To purchase, at a cost that does not exceed the actual cost of reproducing the photocopies, copies of the resident's records on request within two working days' notice to the facility;
24. To select and use a pharmacy of choice provided that the choice is in compliance with facility pharmacy policies and does not result in a situation hazardous to resident health and safety;
25. To have financial and medical records kept in confidence. The release of such records shall be by written consent of the resident or resident's representative, except as other wise required or permitted by law; and
26. To be informed, in writing, of rates and charges and any changes 60 days prior to the change.

Historical Note

Adopted effective February 17, 1995 (Supp. 95-1).

R9-10-907. Admissions

A. The administrator shall ensure that each resident is admitted only on a physician's order and that the resident's care needs do not exceed that for which the facility is licensed.

B. Within 30 days before, or 14 days after the date of admission, the administrator shall ensure that the resident has had a medical history and physical examination completed by those individuals licensed to do so pursuant to A.R.S. Title 32.

C. Prior to or on admission of a resident to the facility, the administrator shall ensure that the resident or the resident's representative enters into an admission agreement which shall include the per diem rate and the services covered, as well as the charges for all other services offered separately.

D. The administrator shall ensure that, upon admission, the resident or resident's representative is informed and provided written information concerning the right to formulate an advance directive, including the facility's policies regarding the implementation of advance directives.

E. At the time of a resident's admission and annually thereafter, the administrator shall ensure that each resident has provided documented evidence that the resident is free from pulmonary tuberculosis as required of personnel in R9-10-903(A)(1) or (2).

F. Prior to, or on admission, the administrator shall ensure that the resident or resident's representative is advised of possible third party coverage for facility services and charges, reasons for transfer or discharge from the facility and the facility's refund policy.

Historical Note

Adopted effective February 17, 1995 (Supp. 95-1).

R9-10-908. Transfers or Discharges

A. The administrator shall ensure that:
1. Notification is provided to the resident if the resident is competent, or to the resident's representative if the resident is incompetent, before instituting a change in room or roommate assignment;
2. A resident is transferred or discharged pursuant to the following:
   a. The resident's needs can no longer be met in the facility and the resident has received a written notice 30 days prior to the transfer or discharge;
   b. The resident's urgent medical needs require immediate transfer or discharge;
   c. The resident's behavior is a threat to the health and safety of individuals in the facility. The discharge shall be documented in the resident's clinical record to demonstrate measures taken to protect the resident and other individuals during pursuit of the discharge to a more appropriate setting; or
   d. The resident has failed, after receiving a 30-day prior notice, to pay for a stay at the facility;
3. Written notification is provided to a resident regarding transfer or discharge pursuant to subsections (2)(a) through (d) and includes the reason and the effective date of the transfer or discharge.

B. If an administrator transfers or discharges a resident under any of the circumstances specified in subsection (A)(2), the clinical record shall contain the following:
1. Documentation regarding the resident's prior notification,
2. Reason for the transfer or discharge, and
3. Physician documentation that the transfer or discharge was necessary for the welfare of the resident or others in the facility or that the resident's needs cannot be met by the facility.

C. The director of nursing shall ensure that:
1. A written discharge summary is completed which includes:
   a. A final summary of the resident's status at the time of discharge,
   b. Past medical or psychosocial history, and
   c. The date and location to which the resident was transferred or discharged; and
2. The resident shall be provided with a written post-discharge plan, developed with the participation of the resident or the resident's representative for the following

purposes: To help the resident adjust to a new living environment; and

b. To provide the resident with the name, address, and telephone number of the state long-term care ombudsman.

D. If a resident is transferred from the facility to the hospital or another nursing care institution, the director of nursing shall ensure that medical and other information needed for care and treatment of the resident is provided to the receiving facility.

Historical Note
Adopted effective February 17, 1995 (Supp. 95-1).

R9-10-909. Service Standards

A. The administrator shall ensure that:
1. The medical care of each resident is supervised by a physician;
2. An attending physician designates an alternate physician when the attending physician is not available;
3. Physician services are provided or arranged 24 hours a day in case of emergency;
4. Each resident receives an annual physical examination by a physician;
5. A resident's physician is consulted, and the resident's representative is notified as soon as possible, when an accident involving a resident occurs which may result in physician intervention or if the resident's health status indicates a significant change in condition; and
6. Residents are assisted, at their own expense, in obtaining the following:
   a. Vision and hearing care services;
   b. Routine and emergency dental care;
   c. Clinical laboratory services from a laboratory licensed pursuant to A.R.S. Title 36, Chapter 4.1;
   d. Mental or psychosocial adjustment services;
   e. Specialized rehabilitative services, including physical, speech, and occupational therapies; and
   f. Special services for mental illness and mental retardation as identified in the resident's assessment.

B. The social services director shall provide medically-related social services in accordance with the resident's assessment and care plan to maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

C. The activities director shall provide for an ongoing program of activities designed to meet, in accordance with resident assessments, the interests and the physical, mental, and psychosocial well-being of each resident taking into consideration the resident's acuity and expected length of stay.

Historical Note
Adopted effective February 17, 1995 (Supp. 95-1).

R9-10-910. Medications

A. The administrator shall ensure that:
1. Pharmaceutical services are provided at the resident's expense, including emergency medications and biologicals, or shall be obtained through an agreement with a pharmacy licensed pursuant to A.R.S. Title 32, Chapter 18 or as otherwise provided by law;
2. The facility complies with all drug-related rules established by the Arizona Board of Pharmacy pursuant to A.R.S. Title 32, Chapter 16;
3. The facility stores all medications and biologicals in locked compartments under manufacturer-required temperature controls with access restricted only to authorized personnel in accordance with state and federal laws;
4. The facility medication error rate, which is determined by calculating the percentage of errors noted during medication administration observation by the surveyor, is less than five percent;
5. A licensed pharmacist reviews the medication regimen of each resident every quarter and reports irregularities, in writing, to the attending physician and the director of nursing;
6. Documented medication irregularities have been acted upon by the attending physician; and
7. A current drug reference source is available for use by staff.

B. The director of nursing shall ensure that:
1. Medication policies and procedures include the following:
   a. A system of records of receipt and disposition of all controlled substances which are reconciled in accordance with the facility's policies and procedures; and
   b. Provisions for separately locked and permanently affixed compartments for the storage of controlled substances listed in A.R.S. § 36-2513, except if the facility uses single-unit package medication distribution systems;
2. Residents are free from significant medication errors;
3. Medication errors are reported to the attending physician and recorded in the resident's clinical record;
4. Adverse medication reactions are reported immediately to the attending physician and recorded in the nurses' progress notes in the resident's clinical record; and
5. Based on a resident's assessment:
   a. Each resident's medication regimen is free from unnecessary drugs;
   b. A resident who has not used antipsychotic medication is given this medication only if antipsychotic medication therapy is necessary to treat a specific condition as diagnosed or documented in the clinical record; and
   c. A resident who uses antipsychotic medication is given gradual dose reductions and behavioral interventions including modification of the resident's behavior or environment, unless clinically contraindicated, in an effort to discontinue antipsychotic medication.

C. A resident may self-administer medications only if the interdisciplinary team has determined that self-administration is safe and the attending physician has approved the self-administration.

Historical Note
Adopted effective February 17, 1995 (Supp. 95-1).

R9-10-911. Food Services

A. The administrator shall appoint a food service supervisor who shall, in consultation with a registered dietician, ensure that:
1. Each resident receives a nourishing, flavorable, well-balanced diet that meets the resident's daily nutritional and special dietary needs, including:
   a. Food prepared by methods that conserve nutritive value, flavor, and appearance; and
   b. Food prepared in a texture designed to meet individual needs, including being cut, chopped, or ground;
2. Menus are prepared 1 week in advance, followed, and are posted in an area accessible to residents;
3. Each resident receives:
   a. Three meals daily with not more than a 14-hour span between the evening meal and breakfast. If a sub-

stantial evening snack was consumed the previous evening, which included meat, fish, eggs, or cheese or other high quality protein, and if a resident group agrees, the 14-hour span may be extended to 16 hours.The option to have a daily bedtime snack;

4. Food substitutions of similar nutritive value are provided to residents who refuse food served.

B. Meals for each day shall include:
1. A total of five servings of fruits and vegetables. A serving size is 1/2 (4 ounces) to 1 cup (8 ounces) of all juices, fruits, and vegetables.
2. A total of six servings of whole grain or enriched cereal, bread, rice, or pasta. A serving size is 1 slice of bread, 1/2 to 1 cup of cereal, or 1/2 cup enriched grain products.
3. A total of two servings of milk, yogurt, or cheese. A serving size is 1 cup of milk or yogurt, 1 1/2 ounces of cheese, or 3/4 cup (6 ounces) of cottage cheese. Cheese is considered both a dairy product and a protein and can be counted as 1 or the other but not both.
4. A total of two servings of protein: meat, fish, poultry, cheese, egg, peanut butter, peas, dry beans, lentils, or equivalent. A serving size is 2 to 3 ounces of lean meat without bone, 1 cup dry beans or legumes, 4 tablespoons of peanut butter, or 2 eggs.

C. Residents shall eat meals in a dining area unless they choose to eat in their rooms or are confined to their rooms for personal or medical reasons.

D. Residents who need help in eating shall be assisted in a manner that recognizes each individual's nutritional and social needs, including the provision of adaptive eating equipment or utensils.

E. Food preparation, storage, and handling shall comply with applicable food and drink rules of A.A.C. Title 9, Chapter 8, Article 1.

Historical Note
Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1).

R9-10-912. Resident Records

A. The administrator shall ensure that clinical records are maintained on each resident which shall contain:
1. Full name, date of birth, social security number, and last address of the resident;
2. Admission date and initial diagnosis;
3. Names, addresses, telephone numbers of the resident's representative and family;
4. The original admission physician orders, history, and physical;
5. Written acknowledgment by the resident or resident's representative of the receipt of a copy of the resident rights and facility rules;
6. Documentation of advance directive information having been provided by the facility on admission, and a copy of advance directives executed by the resident, including a living will or medical power of attorney if one has been appointed;
7. The current address and telephone number of the attending physician;
8. Current annual physical examination;
9. Physician orders and progress notes which are signed and dated;
10. Assessment and care plan;
11. Medications and treatment record;
12. Laboratory and diagnostic reports, including consultations;
13. Progress notes;
14. Documentation of freedom from pulmonary tuberculosis;
15. Documentation of accidents or incidents involving the resident; and
16. Other documentation regarding the resident's health status recorded in the past 90 days.

B. Clinical records shall be legibly recorded in ink, with entries dated and signed with the surname and title of the individual providing the service.

C. Clinical records shall be protected at all times from possible loss, damage or unauthorized use and shall be retained for five years from the date of discharge. If the resident is a minor, the records shall be retained for three years after a resident reaches the age of 18.

Historical Note
Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1).

R9-10-913. Physical Plant Standards

A. Facilities licensed prior to the adoption of these rules shall conform to the requirements of A.A.C. R9-1-412(B), Life Safety Code, Chapter 13, "Existing Health Care Occupancies".

B. Modifications to an existing facility shall meet the same construction and safety code standards for construction of new facilities as required in A.A.C. R9-1-412.

C. All construction of new facilities shall meet the requirements of A.A.C. R9-1-412.

D. Each resident room shall have a window opening to the outside. Window shades or drapes shall be provided as a means of controlling light. Windows shall be located to permit the resident a view from a sitting position.

E. Facilities shall have no more than two beds per resident room except those facilities operating on the effective date of these rules under a license variance permitting more than two beds per resident room. Facilities operating under a license variance that undergo construction or modification as defined in A.R.S. § 36-401(10) and (25) shall have no more than two beds per resident room in any part of the facility that undergoes construction or modification.

F. A resident room or a suite of resident rooms shall be accessible, without passing through another resident's room.

G. A resident room or suite of rooms shall not open into any room in which food is prepared, served or stored.

H. Each resident room or main entry into a suite of rooms shall be numbered.

I. Cubical curtains or similar type separations shall be provided for all multi-bed rooms to ensure privacy.

J. An individual resident care unit shall include a bed, nurse call system, bedside chair, bedside stand, and reading light.

K. All swimming pools shall, unless otherwise required by A.R.S. § 36-1681:
1. Be enclosed by a five-foot solid wall or a five-foot fence with openings not exceeding four inches, and
2. Have 1 or more self-closing and self-latching gates which shall be locked when the pool is not in use.

L. Swimming pools which are used by residents shall:
1. Conform to the minimum requirements for semipublic pools as set forth in state and local rules for design, construction and operation of public and semipublic swimming pools;
2. Have posted pool safety rules; and
3. Be supervised when in use.

Historical Note
Adopted effective October 20, 1982 (Supp. 82-5). Sec-

tion repealed, new Section adopted effective February 17, 1995 (Supp. 95-1).

R9-10-914. Environmental Standards

A. The administrator shall ensure that:
1. Housekeeping and maintenance services are provided to maintain a safe and sanitary environment;
2. The facility maintains a pest control program to control insects and rodents;
3. Equipment is operational and inspected in accordance with the facility's policies and procedures, which shall include the following:
   a. Testing, calibrating, servicing, or repairing equipment;
   b. Maintaining records documenting the service and calibration; and
   c. Maintaining durable medical equipment in good repair and providing it to residents who may require it;
4. The facility complies with infection control policies and procedures that include:
   a. Surveillance, prevention, and control of infection;
   b. Disposal of waste, including blood and body fluid;
   c. Storage and maintenance of sterile supplies and equipment; and
   d. Storage, handling, processing, and transporting of linens, including:
      i. Separately maintained areas for soiled and clean laundry, and
      ii. Containers for clean linen which shall be covered and kept separate from those for soiled linen; and
5. Residents have adequate space and equipment to enable staff to provide the services identified in each resident's assessment and care plan, including:
   a. Individual and group activities,
   b. Community dining areas, and
   c. Special therapies, if provided

B. Staff shall wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice and immediately after handling soiled linen or clothing.

C. Staff with a communicable disease or infected skin lesions shall be prohibited from working in the facility.

D. Staff shall use, maintain, and store oxygen in accordance with A.A.C. R9-1-412(B).

E. Staff shall use and maintain electrical equipment in accordance with A.A.C. R9-1-412(E).

F. Room designated for resident dining and activities shall be ventilated with nonsmoking areas identified.

G. Each resident shall be provided with:
1. A separate bed;
2. Bed and bath linens that are clean, without holes, stains, and not in need of repair;
3. Closet space in the resident's bedroom with clothes racks and shelves accessible to the resident;
4. Lighting that is suitable for the performance of tasks by a resident or staff; and
5. Room temperature levels that are comfortable and safe ranging from 71° to 81° Fahrenheit.

H. The facility shall have outside ventilation by means of windows or mechanical ventilation, or a combination of the two.

I. The facility shall equip corridors with firmly secured handrails on each side.

Historical Note

Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1).

R9-10-915. Safety Standards

A. The administrator shall ensure that the resident environment is maintained as free of accident hazards as possible.

B. The administrator shall be responsible for facility compliance with the safety and emergency plan procedures developed with the assistance of qualified fire safety and emergency preparedness experts. The plan shall include procedures to be followed in the event of a fire, disaster, or other threat to resident safety and shall include the following:
1. Procedures for prompt transportation of casualties and clinical records;
2. Instructions regarding the location and use of alarm systems and fire fighting equipment;
3. Information regarding methods of containing fires;
4. Procedures for notification of the appropriate persons and agencies;
5. Specification of evacuation routes and procedures which shall be posted throughout the facility;
6. Designation of the specific places to which residents may be evacuated; and
7. Detailed arrangements to provide shelter, beds, food, water, medication, nursing care, and any other services critical to the well-being of residents.

C. Employees shall be oriented to emergency preparedness within the first week of employment. The training program shall include ongoing training and drills every six months so that each employee can promptly and correctly perform specific duties in case of a fire, disaster, or other threat to resident safety.

D. There shall be 1 fire drill per shift during each calendar quarter. Records of fire and disaster drills shall be retained for 1 year and include the date, time, scenario, participant list, and a critique of the drill.

E. The facility shall pass an annual inspection for fire safety by the fire authority having jurisdiction.

F. Smoking shall be permitted only in designated areas of the facility.

Historical Note

Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1).

R9-10-916. Quality Management

A. The administrator shall ensure the implementation and maintenance of a quality management program that monitors and evaluates the provision of all aspects of resident care including physician and contracted services.

B. The quality management plan shall be in writing and describe the objectives, organization, scope, and process for improving quality of care and shall include the monitoring activities.

C. The administrator shall maintain a record of quality management activities that includes recommendations for corrective action.

Historical Note

Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1).

R9-10-917. Quality Rating

A. Pursuant to A.R.S. § 36-425.02(A), the Department shall issue each licensed facility, except for provisionally licensed facilities, a quality rating based on an evaluation of the quality of

services provided by the facility. The evaluation shall result from the onsite visit of the facility during the licensure survey.

B. Each facility which has been licensed for 1 year or more shall be evaluated and assigned a quality rating score in accordance with performance criteria outlined in subsection (C). The quality rating score, which can range from 1 to 40 points maximum, shall reflect the facility's performance, as follows:

1. "Excellent performance", if the facility scores a total of 36 or more points resulting in a percentile of 90% to 100%;
2. "Standard performance", if the facility scores a total of 28 to 35 points resulting in a percentile of 70% to 88%; or
3. "Substandard performance," if the facility scores a total of 27 or less points resulting in a percentile of 68% or less.

C. The quality rating shall be based on the facility's compliance with specific standards in the following five evaluation components: This component has eight criteria worth a total of eight maximum points or 1 point each, as follows:

a. The facility does not have any current licensure deficiencies that were cited during the last licensure survey.
b. The facility investigates and reports all allegations involving neglect, abuse, or misappropriation of resident property to the Office of Long-Term Care Licensure and Adult Protective Services, if required by A.R.S. § 46-454, and takes action to prevent further neglect, abuse, or misappropriation of property after the investigations.
c. The facility has a quality management program which addresses resident care standards with documentation that recommendations for correction have been implemented.
d. The facility has a staff person designated to assist and respond, in writing, to grievances and concerns from residents and family groups, and provides evidence of the facility's responsiveness.
e. The facility provides medically related social services to maintain each resident's highest practicable physical, mental, and psychosocial well-being in accordance with the resident's assessment.
f. The facility provides each resident with an ongoing program of activities which meets the resident's interests and physical, mental, and psychosocial well-being in accordance with the resident's assessment.
g. The facility has personnel records for each employee which include documentation of freedom from tuberculosis at the time of hire and annually thereafter.
h. The facility has documentation that personnel, who provide direct care to residents, attend 12 hours of inservice annually.

2. Nursing. This component has four criteria worth a total of eight maximum points or two points each, as follows:
   a. Each resident is provided care and services to maintain the resident's highest practicable physical, mental, and psychosocial well-being in accordance with the resident's assessment.
   b. Each resident is free of significant medication errors that may adversely affect the resident's health, safety, and well-being.
   c. Each resident's medication regimen is free from unnecessary drugs.
   d. In the event of an accident involving a resident, the resident's representative has been notified, and the resident's attending physician has been consulted if the accident requires possible physician intervention, or if the resident's health status indicates a significant change in condition.
3. Resident rights. This component has eight criteria worth a total of eight maximum points or 1 point each, as follows:
   a. Each resident is free from physical and chemical restraints used for purposes other than to treat the resident's medical symptoms.
   b. Each resident is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.
   c. Each resident is treated in a manner that recognizes the resident's right to a dignified existence.
   d. Each resident is allowed to participate in the planning of, or decisions on, care and treatment, including the right to refuse treatment and to formulate an advance directive.
   e. The facility honors each resident's right to personal privacy in accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings with family and resident groups.
   f. The facility helps each resident communicate with resident advocacy agencies by posting the names, addresses, and telephone numbers of these agencies in a conspicuous area.
   g. The facility accommodates each resident's needs in a manner and environment that promotes maintenance and enhancement of a resident's quality of life.
   h. The facility provides each resident, upon discharge, a written plan with information to help the resident adjust to a new environment.
4. Food and nutrition. This component has seven criteria worth a total of seven maximum points or 1 point each, as follows:
   a. The facility provides evidence that a registered dietician has been consulted in determining the nutritional needs of residents; food purchasing; meal planning and production; sanitation; and staff development, training, and participation in developing food service policies.
   b. The facility provides each resident with food that is flavorable, served at a temperature recommended by the dietician, and in a form that meets the resident's needs as specified in the resident's assessment.
   c. Each resident who needs help in eating receives assistance, including the provision of special eating equipment and utensils, in accordance with the resident's assessment.
   d. The facility encourages residents to eat meals in dining areas.
   e. The facility prepares menus 1 week in advance, posts the menus, and adheres to the planned menus.
   f. The facility provides food substitutions with similar nutritive value.
   g. The facility complies with applicable food and drink rules regarding food preparation, storage and handling pursuant to A.A.C. Title 9, Chapter 8, Article 1.
5. Environment. This component has nine criteria worth a total of nine maximum points or 1 point each, as follows:
   a. The facility has implemented policies and procedures to investigate, control, and prevent the spread of infection.
   b. The facility has a hazard-free environment for residents.

c. The facility has common dining areas that are designed, furnished, and decorated in a manner that promotes resident socialization and provides a homelike environment.
d. The facility has provided residents with clean bedding and linens that are in good condition and meet the needs of the residents.
e. Each employee washes his or her hands after each direct resident contact for which handwashing is indicated by accepted professional practice and immediately after handling soiled linen or clothing.
f. The facility maintains an effective pest control program.
g. The facility provides housekeeping and maintenance services that result in a clean, sanitary, and orderly environment.
h. Each employee is oriented to emergency preparedness within the first week of employment and is able to promptly and correctly respond to emergency situations.
i. The facility has corrected deficiencies identified in the annual fire inspections and has implemented recommendations on fire safety issued by the fire authority having jurisdiction for the facility.

D. The facility quality rating category assignment shall remain in effect until the next licensure survey is conducted.

E. If a facility receives a "substandard performance" quality rating, the Department shall review the facility's performance within 60 days to determine if the deficiencies have been corrected.

F. If the Department receives a substantiated complaint that affects the health, welfare, and safety of residents, the Department may reduce the facility's quality rating. Upon correction of the deficiencies, the facility may request, in writing, another review by the Department for an amended quality rating.

G. The quality rating process does not preclude the Department from seeking the assessment of a civil penalty pursuant to A.R.S. § 36-431.01, or suspension or revocation of license pursuant to A.R.S. § 36-424.

H. Each facility's quality rating shall be displayed with the facility license in a public viewing area in the facility.

Historical Note
Adopted effective October 20, 1982 (Supp. 82-5). Section repealed, new Section adopted effective February 17, 1995 (Supp. 95-1).

R9-10-918 Repealed

Historical Note
Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

R9-10-919. Repealed

Historical Note
Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

R9-10-920. Repealed

Historical Note
Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

R9-10-921. Repealed

Historical Note
Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

R9-10-922. Repealed

Historical Note
Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

R9-10-923. Repealed

Historical Note
Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

R9-10-924. Repealed

Historical Note
Adopted effective June 2, 1983 (Supp. 82-5). Former Section R9-10-924 repealed, new Section R9-10-924 adopted effective November 6, 1985 (Supp. 85-6). Repealed effective February 17, 1995 (Supp. 95-1).

R9-10-925. Repealed

Historical Note
Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

ATTACHMENT 1

Historical Note
Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective February 17, 1995 (Supp. 95-1).

ATTACHMENT 2

Historical Note
Adopted effective October 20, 1982 (Supp. 82-5). Repealed effective November 6, 1985 (Supp. 85-6).

Editor's Note: The proposed summary action repealing R9-10-1011 through R9-10-1030 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rules. Sections in effect before the proposed summary action have been restored (Supp. 97-1). Subsequently, those Sections were repealed by final rulemaking (Supp. 99-2).

ARTICLE 10. REPEALED

R9-10-1001. Reserved

R9-10-1002. Reserved

R9-10-1003. Reserved

R9-10-1004. Reserved

R9-10-1005. Reserved

R9-10-1006. Reserved

R9-10-1007. Reserved

R9-10-1008. Reserved

R9-10-1009. Reserved

R9-10-1010. Reserved

R9-10-1011. Repealed

Historical Note
Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1011 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1011 was remanded by the Governor's Regulatory

Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1012. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1012 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1012 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1013. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1013 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1013 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1014. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1014 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1014 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1015. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1015 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1015 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1016. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1016 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1016 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1017. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1017 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1017 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1018. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1018 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1018 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1019. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1019 adopted as an emergency now adopted as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1019 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5,

1999 (Supp. 99-2).

R9-10-1020. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1020 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1020 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1021. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1021 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1021 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1022. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1022 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1022 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1023. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1023 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1023 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1024. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). New Section R9-10-1024 adopted as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1024 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1025. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1025 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1025 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1026. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1026 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1026 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1027. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1027 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1027 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1028. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1028 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1028 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1029. Repealed

Historical Note

Adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Former Section R9-10-1029 adopted as an emergency now adopted and amended as a permanent rule effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1029 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

R9-10-1030. Repealed

Historical Note

Adopted effective February 15, 1984 (Supp. 84-1). Repealed by summary action, interim effective date July 21, 1995 (Supp. 95-3). The proposed summary action repealing R9-10-1030 was remanded by the Governor's Regulatory Review Council which revoked the interim effectiveness of the summary rule. The Section in effect before the proposed summary action has been restored (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 1222, effective April 5, 1999 (Supp. 99-2).

ARTICLE 11. HOME HEALTH AGENCIES

R9-10-1101. Definitions

In this Article, unless the context otherwise requires:

1. "Activities of daily living" means ambulating, communicating, bathing, toileting, grooming, feeding and homemaking.
2. "Advance directives" means a living will, prehospital medical care directive or health care power of attorney.
3. "Branch office" means an office which operates under the license of a parent home health agency and utilizes the same administrator and supervising physician or nurse.
4. "Coordination" means the process by which the patient or patient's representative and caregivers exchange information and combine efforts to develop and revise the plan of care and provide services.
5. "Discharge summary" means a brief review of service, patient status, and reasons for discharge.
6. "Home health aide services" means those tasks which are provided by a home health aide under the supervision of a registered nurse or a therapist.
7. "Home health care team" means the physician, patient or patient's representative, patient's family, and home health service providers.
8. "Medications" means both prescription and nonprescription drugs used by the patient.
9. "Nurse" means an individual licensed pursuant to A.R.S. Title 32, Chapter 15.
10. "Occupational therapist" means an individual licensed pursuant to A.R.S. Title 32, Chapter 34.
11. "Occupational therapist assistant" means an individual licensed pursuant to A.R.S. Title 32, Chapter 34.
12. "Parent home health agency" means the licensed agency that develops and maintains administrative control of branch offices.
13. "Patient's representative" means a person acting on behalf of a patient under the written consent of the patient or the patient's legal guardian, or a surrogate pursuant to A.R.S. § 36-3201(13).
14. "Personal care services" means assistance with activities of daily living and services which are not related to the treatment of a patient's illness or injury.
15. "Pharmacist" means an individual licensed pursuant to A.R.S. Title 32, Chapter 18.
16. "Physical therapist" means an individual licensed pursuant to A.R.S. Title 32, Chapter 19.
17. "Physician" means an individual licensed pursuant to A.R.S. Title 32, Chapters 13 and 17.
18. "Professional services" means medical social work, nutritional services, respiratory care services, and pharmaceutical services.
19. "Registered dietitian" means an individual who holds a bachelor's or master's degree in food and nutrition and is registered with the Commission on Dietetic Registration.
20. "Respiratory care practitioner" means an individual licensed pursuant to A.R.S. Title 32, Chapter 35.
21. "Social worker" means an individual who holds a master's degree from a school accredited by the Council on Social Work Education.
22. "Social work assistant" means an individual who holds a bachelor's degree in counseling, social work, psychology, or sociology.
23. "Speech-language pathologist" means an individual who holds a Certificate in Clinical Competency in Speech-Language Pathology from the American Speech-Language-Hearing Association.
24. "Therapy" means occupational therapy, physical therapy or speech therapy.

Historical Note

Adopted effective July 22, 1994 (Supp. 94-3).

R9-10-1102. Administration

A. A home health agency shall have a governing authority responsible for the agency's operations. The governing authority shall:

1. Adopt and update policies and procedures for the operation and administration of the agency;
2. Appoint an administrator to manage the agency who shall have three years of administrative or supervisory experience which shall include two years of health care experience; and
3. Appoint a professional advisory group which shall:
   a. Consist of four or more members that include:
      i. One practicing physician,
      ii. One registered nurse who has 1 year of experience as a home health nurse, and

iii. Two or more representatives from other health-related professions.

b. Have 25% or more of its members who are not owners, employees, or contractors of the home health agency and who shall:
i. Meet at least every six months,
ii. Record and maintain minutes of all meetings,
iii. Advise the agency on professional issues, and
iv. Assist in establishing, reviewing, and evaluating policies and procedures for the home health agency.

B. The administrator shall organize and manage the agency and shall be responsible for the following:
1. Reporting to the governing authority;
2. Maintaining communication with the governing authority, professional advisory group, staff, and community;
3. Ensuring that the parent home health agency has the capability of providing supervision and services on a daily basis to the branch offices;
4. Appointing a supervising physician who has two years of home health experience or a supervising registered nurse who has three years of nursing experience which includes two years in home health care;
5. Hiring staff in consultation with the supervising physician or registered nurse;
6. Ensuring staff orientation, education, and evaluation;
7. Ensuring that written contractual provisions are complied with by the providers of home health services;
8. Ensuring that providers of therapy and other professional services provide the agency with documentation of a degree, certification, or registration in good standing for the profession specified in R9-10-1101;
9. Ensuring that therapy and other professional services are provided, as follows:
a. Speech therapy or speech-language pathology services shall be provided by a speech-language pathologist.
b. Nutritional services shall be provided by a registered dietitian.
c. Occupational therapy services shall be provided by an occupational therapist or occupational therapist assistant.
d. Physical therapy services shall be provided by a physical therapist.
e. Respiratory care services shall be provided by a respiratory care practitioner or a registered nurse.
f. Pharmacy services shall be provided by a pharmacist.
9. Medical social work shall be provided by a social worker or may be provided by a social work assistant, under the supervision of a social worker. Each social worker shall have 1 year of social work experience in a health care setting.
10. Maintaining the agency's administrative records, quality management activities, personnel records, and policies and procedures;
11. Designating, in writing, a physician or registered nurse who shall have 1 year of home health experience to act in the absence of the supervising physician or registered nurse to ensure that supervisory coverage shall be provided during all operating hours of the agency; and
12. Designating, in writing, an individual to act in the administrator's absence.

C. The supervising physician or registered nurse shall be responsible for the quality, coordination, and supervision of home health services, including the following:
1. Implementing the agency's policies and procedures;
2. Participating in employment decisions affecting nursing, therapy, and other professional personnel;
3. Providing staff orientation, in-service education, and performance evaluations;
4. Coordinating, monitoring, and evaluating contractual services for all services not provided directly by the home health agency; and
5. Recordkeeping of training and education for staff.

D. The supervising physician or registered nurse may also function as the administrator of the home health agency.

Historical Note
Adopted effective July 22, 1994 (Supp. 94-3).

R9-10-1103. Personnel

A. Personnel shall provide services to meet the needs of each patient, according to the patient's plan of care.

B. An employee, prior to being employed and annually thereafter, shall submit 1 of the following as evidence of freedom from pulmonary tuberculosis:
1. A report of a negative Mantoux skin test taken within six months of submitting the report, or
2. A written statement from a physician stating that, upon an evaluation of a positive Mantoux skin test taken within six months of submitting the physician's statement or a history of a positive Mantoux skin test, the individual was found to be free from pulmonary tuberculosis.

C. Personnel providing direct patient care shall attend orientation and six hours of in-service training per year, which may include time spent in orientation. Orientation shall include:
1. Patient care policies and procedures,
2. Infection control policies and procedures, and
3. Patient rights.

D. Home health aides, prior to being assigned patient care tasks, shall complete a home health aide training program which shall include the following subjects:
1. Communication skills;
2. Observation, reporting, documentation of patient status, and the care or service provided;
3. Reading and recording temperature, pulse, and respiration;
4. Basic infection control procedures;
5. Basic elements of body functioning and changes in function that must be reported to a home health aide's supervisor;
6. Maintenance of a clean, safe, and healthy environment;
7. Recognizing emergencies and knowledge of emergency procedures;
8. Physical, emotional, and developmental needs of the populations serviced by the home health agency;
9. Techniques in providing personal hygiene and grooming;
10. Activities of daily living;
11. Transfer techniques;
12. Range of motion and positioning;
13. Nutrition and fluid intake; and
14. Patient rights.

E. The administrator shall ensure that a personnel record for each employee includes the following documentation:
1. Employee name and address;
2. Education and work experience;
3. Verification of any professional license, certification, registration, and education requirements;
4. Initial proof of freedom from pulmonary tuberculosis and annual verification statement, thereafter;
5. Orientation and in-service training records; and

6. Competence and performance evaluations of home health aide and personal care attendant skills.

Historical Note
Adopted effective July 22, 1994 (Supp. 94-3).

R9-10-1104. Home Health Services

A. The supervising physician or registered nurse shall ensure that nursing services shall be managed in accordance with the following:
1. Unless a physician orders therapy services only, a registered nurse shall conduct patient assessments as follows:
   a. The initial assessment shall be conducted within 72 hours of a patient's acceptance into a home health program and shall include a review of advance directives;
   b. Reassessments shall be conducted within 62-day periods thereafter, according to the patient's needs and as the patient's condition warrants; and
   c. The assessments shall include:
      i. Patient needs, resources, family, and environment;
      ii. Goals of patient care;
      iii. Medications used by the patient, including the side effects and contraindications; and
      iv. A listing of required medical supplies and durable medical goods.
2. A registered nurse shall be responsible for the following:
   a. Implementing a patient's plan of care;
   b. Coordinating patient care with other members of the home health care team;
   c. Assigning a licensed practical nurse to provide nursing services in accordance with home health agency policies;
   d. Supervising home health aides and assigning written patient care duties to individual home health aides;
   e. Informing the patient's physician of changes in a patient's condition and needs;
   f. Summarizing the patient's status for submission to the physician, every 62 days or more often, as the patient's condition warrants;
   g. Ensuring that the findings and ongoing services are documented in the medical record for each patient contact;
   h. Participating in the preparation of patient transfer, discharge plan, and discharge summary;
   i. Documenting verbal orders received from the physician in the medical record;
   j. Conducting supervisory visits to the patient who is receiving home health aide services to determine the quality of care being given by the home health aide, according to the following schedule:
      i. Every two weeks when home health aide services together with either nursing services or therapy services are being provided; or
      ii. Every 62 days while only home health aide services are being provided; and
   k. Evaluating, by direct observation of performance, the competency of the home health aide and personal care attendant.

B. The supervising physician or registered nurse shall ensure that home health aide services are provided under the supervision of a registered nurse as follows:
1. Home health aide services shall be provided by an individual who has completed a home health aide training program pursuant to R9-10-1103(D) or by an individual who is in good standing with the State Board of Nursing, Nurse Aide Register.
2. Each home health aide shall:
   a. Perform only those tasks assigned, in writing, by the registered nurse or a therapist pursuant to subsection (C)(4);
   b. Report any observations of change in a patient's condition to the registered nurse; and
   c. Document care provided in the patient's medical record.

C. The supervising physician or registered nurse shall ensure that providers of therapy and other professional services comply with the following:
1. The services shall be ordered by a physician and provided in accordance with the patient's plan of care.
2. A therapist or individual providing professional services shall:
   a. Assist the physician in evaluating the patient's needs;
   b. Participate in developing, evaluating, and revising the plan of care and establishing goals;
   c. Coordinate patient care with other members of the home health care team;
   d. Ensure that the findings and ongoing services are documented in the medical record; and
   e. Participate in the preparation of the patient transfer, discharge plan, and discharge summary.
3. A therapist or provider of professional services shall document any physician orders received pertaining to their respective therapy or professional services.
4. A therapist may supervise a home health aide when a physician orders home health aide and therapy services only. As a supervisor, the therapist shall:
   a. Assign patient care duties, in writing, to the home health aide;
   b. Comply with the assessment requirements in subsection (A)(1); and
   c. Comply with the registered nurse visitation requirements in subsection (A)(2)(j)(i).

Historical Note
Adopted effective July 22, 1994 (Supp. 94-3).

R9-10-1105. Supportive Services

A. Supportive services do not require a physician order and shall be provided in accordance with agency policies.

B. Supportive services may include a personal care attendant who is employed by the agency to provide personal care services only. A registered nurse shall assign personal care tasks, in writing, to the attendant and shall ensure that the attendant documents all care provided in the patient's medical record.

Historical Note
Adopted effective July 22, 1994 (Supp. 94-3).

R9-10-1106. Plan of Care

A. Home health services shall be provided by the home health agency in accordance with a written plan of care established and authorized by a physician in consultation with the patient and other members of the home health care team.

B. The plan of care shall be based on the patient's diagnosis and the assessment of the patient's immediate and long-term needs and shall include the following:
1. Diagnosis;
2. Surgery dates relevant to home health services;
3. Mental status;
4. Functional limitations;
5. Rehabilitation potential;

6. Type and frequency of services to be provided;
7. Treatments, medications, and any drug allergies;
8. Therapy and professional services, procedures, and modalities including the amount, frequency, and duration of service;
9. Activities permitted;
10. Nutritional requirements; and
11. Safety measures to protect against injury.

C. Staff shall document, in the medical record, any verbal order for either the initiation or modification to the plan of care and shall include in the record the physician's verifying signature which shall be obtained within 30 days of the order.

D. The home health care team shall review the plan of care every 62 days or more often, as the patient's need or condition warrants. The review shall include the authorization by the physician for the continuation of the patient's plan of care or the revision thereof.

Historical Note
Adopted effective July 22, 1994 (Supp. 94-3).

R9-10-1107. Patient Rights

A. The administrator shall establish a written policy regarding the rights of patients and shall ensure the agency's compliance thereto.

B. The agency shall give each patient or patient's representative a list of patient rights prior to services being provided.

C. Personnel shall ensure that language barriers or physical handicaps do not prevent each patient or patient's representative from becoming aware of the following patient rights:
1. To be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care needs;
2. To receive medical, nursing, therapeutic, and personal care in accordance with the patient's plan of care;
3. To refuse treatment or withdraw consent for treatment;
4. To participate in the development of the plan of care and any modification thereof;
5. To have personal and private property treated respectfully and not subject to misappropriation;
6. To have financial and medical records kept in confidence. The release of such records shall be by written consent of the patient or patient's representative, except as otherwise required or permitted by law;
7. To be informed of the following:
   a. Financial liability prior to obtaining services or prior to a change in rates, charges or services;
   b. Notice of third-party coverage for agency services; and
   c. The process for registering a complaint with the Office of Health Care Licensure about agency services; and
8. To exercise other civil rights and religious liberties, including the right to submit grievances to the agency, free from restraint, interference, coercion, discrimination, or reprisal.

Historical Note
Adopted effective July 22, 1994 (Supp. 94-3).

R9-10-1108. Medical Records

A. The administrator shall ensure the maintenance of policies and procedures governing the protection and confidentiality of medical records.

B. Each agency shall maintain a medical record for each patient which contains the following:
1. Patient name and address, name of patient's representative, caretaker, and physician;
2. Written acknowledgment that the patient received a copy of patient rights prior to the beginning of care;
3. Documentation concerning advance directives;
4. Medical history, current diagnoses, and findings;
5. Plan of care;
6. Physician orders;
7. Initial and periodic assessments and progress notes that are dated, signed by the person providing the service, and filed weekly;
8. Documentation of each patient contact for care or services;
9. Reports of patient home health service conferences;
10. Reports of patient summaries sent to the physician;
11. Reports of contacts with the physician by staff and the patient;
12. Supervisory reports on home health aide and personal care services; and
13. Patient transfer or discharge plan and discharge summary.

C. Medical records shall be maintained for five years beyond the last date of service provided. If the patient is a minor, the medical record shall be retained for three years after the patient reaches 18 years of age.

Historical Note
Adopted effective July 22, 1994 (Supp. 94-3).

R9-10-1109. Quality Management

A. The administrator shall ensure implementation and maintenance of a quality management program that monitors and evaluates the provision of patient care including contracted services.

B. The quality management plan shall be in writing and describe the objectives, scope, and process for improving quality of care which shall include the monitoring of activities.

C. Each quarter, a group of health care professionals, representing the home health services provided during the previous quarter, shall review a 10% sample or 30 medical records, whichever is lesser. The review shall:
1. Ensure that policies and procedures are followed in providing services directly or under contract; and
2. Be documented as part of the quality management process.

D. The administrator shall maintain a record of quality management activities and ensure that any conclusions and recommendations on findings of quality management activities are reported to the governing authority.

Historical Note
Adopted effective July 22, 1994 (Supp. 94-3).

R9-10-1110. Reserved

R9-10-1111. Repealed

Historical Note
Amended effective September 2, 1977 (Supp. 77-5).
Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1112. Repealed

Historical Note
Amended effective September 2, 1977 (Supp. 77-5).
Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1113. Repealed

Historical Note
Amended effective September 2, 1977 (Supp. 77-5).
Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1114. Repealed

Historical Note
Amended effective September 2, 1977 (Supp. 77-5).
Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1115. Repealed

Historical Note
Adopted effective September 2, 1977 (Supp. 77-5).
Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1116. Repealed

Historical Note
Adopted effective September 2, 1977 (Supp. 77-5).
Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1117. Repealed

Historical Note
Adopted effective September 2, 1977 (Supp. 77-5).
Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1118. Repealed

Historical Note
Adopted effective September 2, 1977 (Supp. 77-5).
Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1119. Repealed

Historical Note
Adopted effective September 2, 1977 (Supp. 77-5).
Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1120. Repealed

Historical Note
Adopted effective September 2, 1977 (Supp. 77-5).
Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1121. Repealed

Historical Note
Adopted effective September 2, 1977 (Supp. 77-5).
Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1122. Repealed

Historical Note
Adopted effective September 2, 1977 (Supp. 77-5).
Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1123. Repealed

Historical Note
Adopted effective September 2, 1977 (Supp. 77-5).
Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1124. Repealed

Historical Note
Adopted effective September 2, 1977 (Supp. 77-5).
Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1125. Repealed

Historical Note
Adopted effective September 2, 1977 (Supp. 77-5).
Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1126. Repealed

Historical Note
Adopted effective September 2, 1977 (Supp. 77-5).
Repealed effective July 22, 1994 (Supp. 94-3).

R9-10-1127. Repealed

Historical Note
Adopted effective September 2, 1977 (Supp. 77-5).
Repealed effective July 22, 1994 (Supp. 94-3).

ARTICLE 12. INFIRMARY

R9-10-1201. Reserved

R9-10-1202. Reserved

R9-10-1203. Reserved

R9-10-1204. Reserved

R9-10-1205. Reserved

R9-10-1206. Reserved

R9-10-1207. Reserved

R9-10-1208. Reserved

R9-10-1209. Reserved

R9-10-1210. Reserved

R9-10-1211. General

A. Infirmaries to which these requirements apply are subject to inspection as provided in A.R.S. §§ 436-406 and 36-424. Department personnel are prohibited by A.R.S. § 36-404 from disclosing patient records or any information from which a patient or his family might be identified, or sources of information which cause the Department to believe that an inspection is needed to determine whether an institution is in compliance with the provisions of this Chapter and the regulations thereunder.

B. The infirmary's administration shall assure that contract suppliers meet the same standards of quality the infirmary would have to meet if services were provided by the infirmary.

C. Regulations contained in this Article shall not be construed to compel any patient to submit to any examination or treatment provided all requirements for control of communicable disease and sanitation are met.

Historical Note
Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-1212. Definitions

Unless the context otherwise requires:

1. "Attendant population" means the staff and students of a school, the members of an association or the clients or wards of a public agency.
2. "Chief executive officer" means a qualified person appointed by the governing authority to act in its behalf in the overall management of the infirmary.
3. "Food service director" means a person who is a dietitian or a graduate of a dietetic technician, dietetic assistant or food service supervisor training program, correspondence school or classroom, approved by the American Dietetic Association, or who has training and experience in food service supervision and management equivalent to 1 of these programs.
4. "Infirmary" is a class of health care institution having 30 or less inpatient beds and providing limited hospital services to the staff and students of a school, the members of an association or the clients or wards of a public agency.
5. "Licensed bed capacity" means the number of beds specified on the infirmary's license.

Historical Note
Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-1213. Administration

A. Governing authority: The governing authority shall adopt policies which identify the purposes of the infirmary and the methods of fulfilling them. The governing authority shall appoint a chief executive officer who shall be appropriately qualified for the management of the facility. The chief executive officer shall have authority and responsibility for the operation of the infirmary.

B. The chief executive officer shall be directly responsible for the management and operation of the infirmary and shall, when there is an organized medical staff, provide liaison between the governing body and the medical staff.

1. When there is a planned change of the chief executive officer or ownership, the governing authority shall notify the Department at least thirty days prior to the effective date of change. Such changes that cannot be planned in advance shall be reported in writing to the Department immediately.
2. There shall be written admission and discharge policies which are consistent with the established purposes of the infirmary.
3. Upon admission inpatients shall be provided a suitable device or method for identification.
4. The following documents or copies shall be available in the infirmary:
   a. Policies of the governing authority,
   b. By-laws and rules and regulations of the medical staff,
   c. Policies and procedures for all established infirmary services,
   d. Reports of all inspections and reviews related to licensure for the preceding five years together with corrective actions taken.
   e. Contracts related to licensure to which the infirmary is bound,
   f. Appropriate documents evidencing control and ownership,
   g. A current copy of Title 9 Health Care Regulations available from the Office of the Secretary of State which includes:

Chapter 1, Article 4	Codes and Standards Referenced
Chapter 8, Article 1	Food and Drink
Chapter 9, Articles 1,2,3	Health Care Institutions: Establishment and Modification
Chapter 10, Article 1	Health Care Institutions: Licensure
Chapter 10, Article 12	Health Care Institutions: Infirmary

5. The Department recognizes that emergency situations do occur in which the infirmary may temporarily need to exceed its licensed bed capacity. The medical need to admit patients in excess of the licensed bed capacity shall be monitored by a physician, and only a physician shall admit patients until the census is reduced to the licensed bed capacity.
6. Personnel
   a. Personnel records:
      i. A record of each employee shall be maintained which includes the following:
         (1) Employee's identification, including name, address and next of kin,
         (2) Resume of education and work experience,
         (3) Verification of valid license if required, education and training.
      ii. Payroll and attendance records for the preceding 12-month period shall be available for review by Department personnel.
      iii. Every position shall have a written description of the duties of the position.
   b. New employees shall receive orientation to familiarize them with the facility, its policies, and the responsibilities of the new employee.
   c. An in-service training program shall be conducted on a continuing basis for all nursing personnel and shall be available for others. Records shall be maintained that include at least subject matter, attendance, and date of training.
   d. An employee whose duties during his normal work shift require him to be awake while on the job shall not be scheduled to work consecutive shifts.
   e. Pre-employment and annual medical screenings shall be conducted. These shall include a medical history and an appropriate tuberculosis screening test. A physical examination shall be accomplished of those persons whose medical screening indicates such a need.
7. Miscellaneous
   a. There shall be no pets allowed in the infirmary. For the purpose of these regulations, seeing eye dogs and hearing ear dogs are not considered pets.
   b. The person on duty and in charge of the infirmary shall have reasonable access to all areas of the infirmary.
   c. Reasonable privacy shall be provided for all patients.

Historical Note
Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-1214. Medical staff

A. The infirmary shall not be required to have an organized medical staff. However, if there is an organized medical staff, they shall be responsible to the governing authority for the quality of medical care provided to patients and for the professional and ethical practices of its members.

B. Patients may be admitted to the infirmary by the person on duty. In infirmaries with organized medical staff, admittance shall be in accordance with medical staff by-laws. In all infirmaries Medical Services to Patients shall be under the direction of a physician. (See R9-10-113 for definitions of "Medical Services" and "Direction".)

C. The organized medical staff subject to final approval of the governing authority shall adopt by-laws, rules and regulations, and policies for the proper conduct of its activities. The medical staff shall recommend to the governing authority, physicians and other licensed practitioners considered eligible for new and continued membership on the medical staff, as delineated in medical staff by-laws. Clinical privileges of each medical staff member shall be delineated in writing.

D. In those infirmaries having an organized medical staff, the by-laws shall state the type, purpose, composition and organization of standing committees.

E. The medical staff shall be responsible to assure the availability of inpatient and outpatient physician services in the event of an emergency.

Historical Note
Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-1215. Nursing services

A. Organization
1. The infirmary shall have an organized nursing service to provide nursing care to meet the needs of each patient, and the attendant population.
2. Administrative and patient care policies and procedures for all nursing services provided shall be developed, periodically reviewed, and revised as necessary.

B. Staffing
1. The nursing department shall be adequately staffed at all times based upon the number of patients and their acuity.
   a. A registered nurse shall be in charge of the nursing service at all times.
   b. There shall be at least 1 registered nurse present in the infirmary at all times. When there are 25 or more inpatients, there shall be an additional licensed nurse on duty. In addition, there shall be at least 1 other staff person immediately available to the infirmary within five minutes.
2. A staffing schedule shall be maintained.

Historical Note

Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-1216. Surgical services

An infirmary shall not provide surgical services.

Historical Note

Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-1217. Dietetic services

A. If the infirmary has a dietetic department, it shall meet the requirements of general hospital dietetic services regulations R9-10-217.

B. If the infirmary does not maintain a dietetic department, it shall meet the requirements of food service sanitation in accordance with the Department's regulations contained in A.C.R.R. Title 9, Chapter 8, Article 1, "Food and Drink".

Historical Note

Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-1218. Emergency services

A. An infirmary is not required to staff or equip a full-time emergency department, but necessary emergency medical services shall be provided in a designated area of the infirmary to meet the needs of the attendant population.

B. Emergency services shall be provided to any of the attendant population in need of them. If the infirmary offers only a partial range of services and elects to transfer the patient for further care, essential life-saving measures and emergency procedures shall be instituted that will minimize aggravation of the condition during transportation. A patient shall be transferred only to a receiving institution that has consented to accept that patient. A record of the immediate medical problem and treatment provided shall accompany the patient.

C. There shall be written policies adopted by the governing authority establishing the extent of treatment to be carried out by the infirmary. These written policies shall provide for transfer to facilities offering more comprehensive care.

D. An infirmary that desires to provide full emergency room services shall meet the requirements of R9-10-218.

Historical Note

Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-1219. Disaster preparedness

Disaster plan: There shall be a written plan of operation with procedures to be followed in the event of a disaster.

Historical Note

Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-1220. Environmental services

A. Policies and procedures for investigating, controlling and preventing infections in the infirmary shall be adopted which shall include specific isolation procedures. All cases of reportable diseases shall be reported in accordance with applicable rules and regulations adopted by the Department. There shall be a policy requiring sterile supplies to be reprocessed at specified time periods.

B. The infirmary shall be kept clean, free of insects, rodents, litter and rubbish. All areas shall be regularly and appropriately cleaned in accordance with administrative policies and procedures.

C. The infirmary physical plant, including equipment, shall be periodically inspected and, where appropriate, tested, calibrated, serviced or repaired to assure that all equipment is free of fire and electrical hazards and is functioning properly. Records shall be maintained to assure that appropriate inspections and maintenance of equipment are periodically accomplished by qualified personnel.

D. There shall be available at all times clean linen essential to the proper care and comfort of the patients. Linens shall be handled, stored, processed or transported in a manner which will prevent the spread of infection.

E. All potentially hazardous wastes such as waste from isolation rooms and disposable materials contaminated with secretions, excretions or blood and patient care wastes, laboratory wastes and the like shall be sterilized by autoclaving and buried in a Department approved sanitary landfill or may be disposed of by incinerating in an incinerator approved by the Air Pollution Control Officer having jurisdiction. If only 1 autoclave is available and an incinerator is not available, the waste shall be double bagged, clearly marked and shall be taken to a Department approved landfill. The operator of the landfill shall be notified and immediate burial assured. Provisions of A.C.R.R. Title 9, Chapter 8, Article 4 pertaining to disposal of such material shall be observed.

F. When oxygen is being used, the following precautions shall be taken:
1. A warning sign shall be placed at each entrance to the room.
2. Ash trays, matches, and other smoking material shall be removed from the room.
3. Oxygen tanks shall be secured at all times. Additional precautions shall be taken in accordance with the Life Safety Code adopted by reference in R9-1-412(B) and the Inhalation Anesthetics Code adopted by reference in R9-1-417(A).
4. Hydrocarbon greases shall not be used.

G. Electrical safety
1. Extension cords shall not be used except for maintenance services.
2. Additional precautions shall be taken in accordance with the National Electrical Code adopted by reference in R9-1-412(E).

H. There shall be written policies concerning syringe and needle storage, handling and disposal.

I. Water supply shall be in accordance with the Department's regulations contained in A.C.R.R. Title 9, Chapter 8, Article 2.

J. Sewage systems shall be in accordance with the Department's regulations contained in A.C.R.R. Title 9, Chapter 8, Article 3.

Historical Note

Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-1221. Medical records services

A. There shall be a medical records department under the direction of a designated person and with adequate staff and facilities to perform all required functions. If the designated person is not qualified in medical records management, consultation or training from a qualified person shall be provided.

B. A medical record shall be established and maintained for every person receiving treatment as an inpatient, outpatient, or on an emergency basis in any unit of the infirmary. The records shall be available to other units engaged in care and treatment of the patient.

C. Only authorized personnel shall have access to the records.

D. Medical records shall be released only with the written consent of the patient, the legal guardian, or in accordance with the law.

E. For licensing purposes, medical records shall be readily retrievable for a period of not less than three years except that A.R.S. § 36-343 requires retention of vital records and statistics for ten years.

F. The original or signed copy of all clinical reports shall be filed in the medical record.

G. Within 48 hours of admission, a current or updated history and physical examination or nursing evaluation shall be in the record.

H. When a patient is readmitted within 30 days for the same problem, there shall be at least a reference to the previous history by an interval note.

I. When authorized by the medical staff, physician's assistants and nurse practitioners may write or dictate medical histories and results of physical examinations. Such entries shall be countersigned by the attending physician.

J. All entries in the record must be dated and signed or initialed by the person making the entry. If initials are used, a method must be established to identify authorship.

K. Medical records of discharged patients shall be completed within time limits established by policies of the infirmary.

L. Inpatient medical records shall contain the following information, if applicable:
1. Patient's identification sheet, including name, address, date of birth, sex, person to be notified in an emergency, and a unique identifying number.
2. History and physical examination or nursing evaluation.
3. Physician's orders and progress notes.
4. Laboratory and diagnostic reports.
5. Nursing notes.
6. Medication and treatment records.
7. Admitting diagnosis.
8. Disposition and discharge diagnosis.
9. Record of informed consent.
10. Discharge summary.

M. The outpatient's medical record shall be accessible and contain the following information:
1. Patient's identification.
2. That information pertaining to the patient's chief complaint including but not limited to physician's orders, treatment or services provided, and disposition.

N. Emergency service records shall contain the following:
1. Patient's identification.
2. Record of any treatment patient received prior to arrival.
3. History of disease or injury.
4. Physical findings.
5. Laboratory and x-ray reports, if applicable.
6. Diagnosis.
7. Record of treatment.
8. Disposition.
9. Name of physician who ordered the emergency treatment.

O. All deaths, abortional acts, post-mortem procedures and births shall be reported in accordance with A.C.R.R. Title 9, Chapter 19.

P. A list of symbols or abbreviations shall be compiled by the staff and approved by the chief executive officer. A current copy shall be maintained at each nursing unit, at each department making entries in the record, and in the medical record department.

Historical Note
Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-1222. Laboratory services

If laboratory services are performed, the laboratory shall be licensed as an independent clinical laboratory.

Historical Note
Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-1223. Pharmaceutical services

The infirmary shall maintain pharmaceutical services which comply with A.R.S. Title 36, Chapter 9, and A.R.S. Title 32, Chapter 18 and all applicable regulations adopted by the Board of Pharmacy pursuant thereto.
1. Procedures shall be established to assure that drugs are administered only by persons authorized by state statutes and regulations.
2. Procedures shall be established to ensure that drugs are checked against physician's orders, that the patient is identified prior to administration of the drug, that each patient has an individual medication record, and that the dose of a drug administered to that patient is properly recorded therein by the person who administers the drug.
3. Drugs and biologicals shall be administered as soon as possible by a physician or a licensed nurse.

Historical Note
Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-1224. Rehabilitation services

A. For purposes of this Section rehabilitation services include physical therapy, occupational therapy, speech therapy, or audiology services.

B. The following provisions shall be met in infirmaries that provide rehabilitation services:
1. Rehabilitation services shall be provided by a qualified therapist and only when ordered by a physician. Rehabilitation services may be provided by qualified aides and assistants only when there is a qualified therapist on the premises.
2. There shall be written administrative and patient care policies and procedures for each of the rehabilitation services offered.
3. There shall be a written plan for each patient indicating the modality or type of treatment provided and the frequency of treatment. This plan shall be based on the written order or referral of a physician.
4. There shall be written documentation in the patient's medical record of the rehabilitation services provided.

Historical Note
Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-1225. Reserved

R9-10-1226. Radiology services

If the infirmary provides radiology services:

1. A physician shall be responsible for the medical direction of the radiology services.
2. There shall be a radiologic procedure manual available to radiology service personnel.
3. X-ray examinations shall be performed only when ordered by a person authorized by law. The request for x-ray shall contain a concise statement of the reason for the examination.
4. The radiology services shall be staffed, equipped and operated in accordance with A.R.S. Title 30, Chapter 4 and regulations adopted thereunder.

Historical Note
Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-1227. Respiratory care services
Infirmaries that provide respiratory care services shall meet the following provisions:
1. Respiratory care services shall include therapeutic procedures and may include diagnostic procedures.
2. Respiratory care services shall be provided in accordance with the written order of a physician. The order shall state the modality to be used, the type, frequency and duration of treatment and type and dose of medication including dilution ratio.
3. Reports of respiratory care services shall be made a part of the patient's medical record.
4. Respiratory therapy shall be administered by qualified personnel.

Historical Note
Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-1228. Obstetrical services
An infirmary shall not provide obstetrical services.

Historical Note
Adopted effective February 4, 1981 (Supp. 81-1).

R9-10-1229. Reserved

R9-10-1230. Physical plant construction standards
A. Documentation submittals:
1. The chief executive officer shall provide annually with his license application a certificate of compliance with safety standards as adopted by the fire department having jurisdiction or a plan of corrective action as required.
2. Physical plant drawings shall be submitted to the Department prior to initial licensing. Drawings shall be of such scope and detail as to enable determination of complete compliance of this Article.

B. Minimum safety standards for infirmaries in continuous operation as infirmary on and after May 1, 1980.
1. Exiting:
   a. Each patient room shall have direct exit access through corridors, stairways, lobbies, or lounges to the exterior. Patients shall not exit through another patient room.
   b. Exit access passageways shall be kept clear at all times to permit emergency evacuation.
   c. Patient bedroom shall be equipped with swing type doors which when closed will effectively resist the passage of smoke. Doors shall not be blocked by any object to prevent closing.
   d. Wheel chair patients shall be housed only in patient bedrooms where 32 inch (81.28 cm) wide doors permit access to exterior exits and to toilet facilities.
   e. At least two remote exterior exits shall be accessible by persons in wheelchairs.
   f. A written procedure shall be established for the safe relocation or evacuation of the patients when doors to patient rooms and exit doors are required to be locked (e.g., penal institutions).
   g. Interior stairways shall be enclosed by construction having 1-hour fire-resistive materials.
2. Safety:
   a. A functioning sprinkler head or products of combustion detectors shall be located in patient bedrooms, corridors, and interior stairways.
   b. An appropriate number of sprinkler heads, products of combustion detectors, or heat detectors shall be located to provide adequate protection in kitchens, furnace or boiler rooms, utility rooms, attic spaces, and storage areas.
   c. Each floor of a building, with a gross floor area exceeding 22,500 square feet (2090.75 square meters) which houses an infirmary shall have a smoke barrier partition installed in accordance with the standards adopted by regulation R9-1-412(B) (Life Safety Code). The smoke barrier partition shall divide the infirmary into separate compartments to provide areas of refuge on both sides of the barrier.
   d. Portable fire extinguishers shall be provided in corridors, kitchens, and mechanical unit rooms, and maintained in accordance with the standard adopted by regulation R9-1-412(B).
   e. The physical plant shall be maintained to ensure a safe and healthful environment for patients and staff.
   f. An approved fire alarm system shall be provided in each facility. Pull boxes shall be located at the exit doors. The sprinkler system, products of combustion detectors, heat detectors, and magnetic hold-open door releases, where provided, shall be electrically interconnected to the fire alarm system.
3. Toilet and bath accommodations:
   a. Access to toilet and bathrooms shall not require a patient to pass through another patient room.
   b. At least 1 toilet and 1 lavatory shall be provided for each eight beds or fraction thereof.
   c. Toilets and lavatories for staff shall be separate from patients' accommodations.
   d. At least 1 tub or 1 shower shall be provided for each 15 beds or fraction thereof.
   e. Tubs and showers shall be equipped with grab bars.
4. Electrical:
   a. Electrical systems shall be routinely inspected by a qualified person to ensure maximum safety. No exposed wiring shall be permitted other than appliance electrical cords.
   b. Exit signs, surface illuminated or illuminated from within, shall be located at each exit and where directional signs are necessary.
   c. Automatic emergency power, supplied by generator or battery, shall be available to provide lighting in corridors, exits, nurses' station, exit signs, and power to fire alarms and smoke detectors.
5. Ventilation:
   a. All patient bedrooms shall have a window to the exterior. The window shall be screened and operable for ventilation.
   b. Toilet rooms and bathrooms shall be ventilated by means of mechanical exhaust fans, gravity vents to the exterior, or operable window.
   c. Heating and cooling shall be adequate to ensure comfort of patient and staff.

d. Mechanical units for heating or cooling shall be designed to prevent patient and staff injury.

C. Minimum standards for infirmaries commencing operation after May 1, 1980 and for additions and alterations to licensed facilities.

1. Exiting:
   a. Exit corridors shall be at least 6 feet (1.83 m) in clear width.
   b. Exit doors and patient bedroom doors shall be at least 36 inches (91 cm) in clear width and be of swing type.
   c. Patient bedroom doors shall be a minimum of 1 3/4 inch (3.45 cm) solid wood core construction, or equal.
2. Toilet and bathroom accommodations:
   a. At least 1 toilet and 1 lavatory shall be provided for each four beds, or fraction thereof.
   b. At least 1 tub or shower shall be provided for each ten beds, or fraction thereof.
3. Construction:
   a. Construction shall consist of a minimum of 1-hour fire resistivity as determined by the code adopted by regulation R9-1-412(A) (Uniform Building Code).
   b. Smoke barrier partitions shall be installed in accordance with the standard adopted by regulation R9-1-412(B).
   c. Provisions for handicapped persons shall be provided in accordance with the standard adopted by regulation R9-1-412(I) (Handicapped Standards ANSI A117.1).
4. Electrical:
   a. Electrical systems shall conform to the standard adopted by regulation R9-1-412(E) (National Electrical Code).
   b. Smoke detectors shall be installed in accordance with the standard adopted by regulation R9-1-412(B).
5. An automatic fire extinguishing system shall be provided throughout the facility in accordance with the standards adopted by regulation R9-1-412(G) (National Fire Protection Association, Standard 13).

Historical Note
Adopted effective February 4, 1981 (Supp. 81-1).

Editor's Note: The following Article was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

ARTICLE 13. REPEALED

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-1301. Repealed

Historical Note
Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Reference in paragraph (24) corrected (Supp. 94-2). Section R9-10-1301 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-1302. Repealed

Historical Note
Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1302 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-1303. Repealed

Historical Note
Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1303 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to

Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-1304. Repealed

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted without change effective November 25, 1992 (Supp. 92-4). Section R9-10-1304 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-1305. Repealed

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1305 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-1306. Repealed

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1306 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-1307. Repealed

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1307 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-1308. Repealed

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992

(Supp. 92-4). Section R9-10-1308 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-1309. Repealed

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1309 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-1310. Repealed

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1310 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-1311. Repealed

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1311 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-1312. Repealed

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1312 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-1313. Repealed

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992

(Supp. 92-4). Section R9-10-1313 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

R9-10-1314. Repealed

Historical Note

Emergency rule adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency rule adopted again effective August 27, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Adopted with changes effective November 25, 1992 (Supp. 92-4). Section R9-10-1314 repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

ARTICLE 14. RECOVERY CARE CENTERS

R9-10-1401. Definitions

In this Article, unless the context otherwise requires:

1. "Advance directives" means a living will, prehospital medical care directive, or health care power of attorney.
2. "Basic life support procedures" means emergency services that include the administration of oxygen and cardiopulmonary resuscitation.
3. "Chemical abuse" means the use of a pharmacologic drug administered for purposes of discipline or convenience, which is not required to treat the patient's medical symptoms.
4. "Disaster" means an unforeseen event such as a fire or flood which may result in the facility, or a portion thereof, becoming uninhabitable and which necessitates evacuation of patients to another location.
5. "Licensed nurse" means an individual licensed pursuant to A.R.S. Title 32, Chapter 15.
6. "Medical peer review" means the participation by a physician in the review and evaluation of the medical management of a patient and the use of resources for patient care.
7. "Medical staff" means physicians and other health care providers as defined in medical staff bylaws.
8. "Nursing personnel" means a licensed nurse or a nurse aide.
9. "Patient's representative" means a person acting on behalf of a patient under the written consent of the patient or the patient's legal guardian.
10. "Postdiagnostic" means the medical and nursing care given following a diagnostic procedure.
11. "Postsurgical" means the medical and nursing care given following a surgical procedure.

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1).

R9-10-1402. Administration

A. The governing authority shall consist of 1 or more persons who shall be responsible for the following:
1. Organizing the facility;
2. Adopting bylaws and facility policies and procedures;
3. Approving membership on the medical staff;
4. Delineating, in writing, the clinical privileges of each medical staff member;
5. Ensuring that 1 or more physicians conduct medical peer reviews in accordance with the medical staff bylaws; and
6. Ensuring compliance with state laws, rules, and local ordinances.

B. The governing authority shall appoint an administrator who shall have the authority and responsibility to manage the facility. The administrator shall:
1. Act as a liaison between the governing authority, medical and facility staff;
2. Establish and implement written facility policies and procedures governing:
   a. Personnel employment, orientation, staffing, and recordkeeping;
   b. Patient admissions, rights and responsibilities, medical treatment, and recordkeeping;
   c. Contract services;
   d. Food services, housekeeping, maintenance, and infection control;
   e. Quality management and recordkeeping;
   f. Emergency treatment and disaster plan; and
   g. Equipment inspection; and
3. Designate, in writing, an individual to be on duty, in charge and have access to all areas related to patient care and operation of the physical plant when the administrator is not present.

C. The administrator may contract for services including dietary, pharmaceutical, and laboratory services and shall ensure that contractual services are provided in accordance with the facility's written policies and procedures. Copies of current written agreements containing the terms and conditions for the delivery of contract services shall be kept at the facility.

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1).

R9-10-1403. Patient Rights

A. The administrator shall ensure that each patient or patient's representative is given a list of patient rights and responsibilities at the time of, or prior to, admission. The patient or patient's representative shall acknowledge, in writing, receipt of patient rights and responsibilities.

B. The administrator shall post a list of patient rights and responsibilities in a conspicuous area.

C. The administrator and staff shall ensure that language barriers or physical handicaps do not prevent each patient or patient's representative from becoming aware of patient rights.

D. Each patient shall have the following rights:
1. To be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and care for personal needs;
2. To be free from the following:
   a. Medical, psychological, physical, and chemical abuse; and
   b. Physical restraints, with the exception of an emergency when a restraint is necessary to protect the patient from injury to self or others, and is authorized by the attending physician;

3. To refuse treatment or withdraw consent for treatment;
4. To have medical and financial records kept in confidence. The release of such records shall be by written consent of the patient or the patient's representative except as otherwise required or permitted by law;
5. To have access to the patient's medical record;
6. To be informed of rates and charges, in writing, within two weeks prior to admission for the services offered, and advised of possible third party coverage;
7. To be advised on the facility's policy regarding advance directives;
8. To be included in decisions regarding care and treatment;
9. To associate and communicate privately with persons of the patient's choice;
10. To have access to a public telephone, unless bedside telephones are provided; and
11. To submit grievances without retaliation.

E. Facility staff shall assist each patient to exercise patient rights.

Historical Note
Adopted effective February 1, 1994 (Supp. 94-1).

R9-10-1404. Personnel

A. Personnel, prior to being employed and annually thereafter, shall submit 1 of the following as evidence of freedom from pulmonary tuberculosis:
1. A report of a negative Mantoux skin test taken within six months of submitting the report; or
2. A written statement from a physician stating that, upon an evaluation of a positive Mantoux skin test taken within six months of submitting the physician's statement or a history of a positive Mantoux skin test, the individual was found to be free from tuberculosis.

B. Personnel shall attend orientation within the first week of employment. Orientation shall include personnel policies and procedures and patient rights.

C. Nursing personnel shall:
1. Be 18 years of age or older;
2. Be certified in cardiopulmonary resuscitation within the first month of employment and maintain current certification thereafter;
3. Attend additional orientation which shall include patient care and infection control policies and procedures; and
4. Attend 12 hours of in-service training per year which may include time spent in orientation.

D. The administrator shall ensure that personnel records are maintained which include:
1. Application for employment;
2. Verification of training, registration, certification, or licensure;
3. Initial proof of freedom from tuberculosis and annual verification statement thereafter; and
4. Orientation and in-service training records that include:
   a. Subject matter,
   b. Date and length of in-service, and
   c. Signatures of those who attend.

Historical Note
Adopted effective February 1, 1994 (Supp. 94-1).

R9-10-1405. Nursing Services

A. The administrator shall appoint a director of nursing who shall be responsible for the management and supervision of nursing services which shall include the following:
1. Developing and implementing nursing and patient care policies and procedures for all nursing services, including:
   a. Admission nursing assessments,
   b. Administration of medications to ensure that medications are given according to the physician's order,
   c. Storage of medication to ensure security and efficacy, and
   d. Disposal of medication;
2. Designating, in writing, a registered nurse to act in the absence of the director of nursing;
3. Staffing the facility with nursing personnel according to the number of patients and their health care needs;
4. Ensuring that each patient receives care and services based on the admission nursing assessment and the physician's orders; and
5. Ensuring that medications are administered by a nurse licensed pursuant to A.R.S. Title 32, Chapter 15 or as otherwise provided by law.

B. A registered nurse shall complete a nursing assessment of each patient, which addresses all patient care needs, upon the patient's admission to the facility.

C. A license nurse shall provide the patient with written discharge instructions based on the patient's health care needs and physician's instructions.

Historical Note
Adopted effective February 1, 1994 (Supp. 94-1).

R9-10-1406. Admissions

A. A physician shall admit to the facility only those patients who require recovery care services pursuant to A.R.S. § 36-448.51(2).

B. Facility staff shall comply with the admission policies and procedures of the facility in providing postsurgical and postdiagnostic medical and nursing services.

C. The administrator shall ensure that the following documents are in the patient's medical record at the time of admission:
1. A current history and physical examination performed or approved by members of the medical staff within 30 days of admission,
2. A discharge summary from the referring facility or physician,
3. Physician orders, and
4. Documentation concerning advance directives.

Historical Note
Adopted effective February 1, 1994 (Supp. 94-1).

R9-10-1407. Ancillary Services

A. Laboratory services shall be provided on the premises or available through contract with a laboratory licensed or exempt from licensure pursuant to A.R.S. Title 36, Chapter 4.1.

B. Pharmaceutical services shall be provided on the premises, or available through contract, by a pharmacy registered by the State of Arizona pursuant to A.R.S. Title 32, Chapter 18.

C. The administrator shall designate a food service manager who shall ensure that:
1. Each patient receives a diet based on the patient's nutritional needs and physician's order;
2. Food services are provided in compliance with the facility's policies and procedures;
3. Staff are employed to ensure the preparation and delivery of food;
4. An updated therapeutic diet reference manual is available; and
5. On-site or catered food preparation, storage, and handling shall comply with applicable food and drink rules of Chapter 8, Article 1 of this Title.

Historical Note
Adopted effective February 1, 1994 (Supp. 94-1).

R9-10-1408. Quality Management

A. The administrator shall ensure implementation and maintenance of a quality management program that monitors and evaluates the provision of all aspects of patient care including contracted and physician services.

B. The quality management plan shall be in writing and describe the objectives, organization, scope, and process for improving quality of care which shall include the monitoring activities.

C. The administrator shall maintain a record of quality management activities and ensure that any conclusions and recommendations on findings of quality management activities are reported to the governing authority.

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1).

R9-10-1409. Medical Records

A. The administrator shall ensure that a medical record is established and maintained for each patient in accordance with the facility's policies and procedures.

B. Medical records for each patient shall include the following information, where applicable:

1. Patient name and address,
2. Admitting diagnosis,
3. Discharge summary from the referring facility or physician,
4. Written acknowledgment of the receipt of copies of patient rights and responsibilities,
5. Consent forms,
6. Documentation concerning advance directives,
7. Medical history and physical examination,
8. Physician orders and progress notes,
9. Nursing assessment and progress notes,
10. Medication and treatment record,
11. Laboratory and diagnostic reports, and
12. Documentation that the patient received discharge instructions.

C. The administrator shall ensure that the medical record of a discharged patient is completed within 30 days of the discharge.

D. Medical records shall be maintained for three years from the patient's discharge except as required by A.R.S. § 36-343. If a facility ceases operation, the recovery care center shall ensure the preservation of records in compliance with this retention requirement.

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1).

R9-10-1410. Environmental Standards

A. The administrator shall ensure the facility's compliance with the infection control policies and procedures which shall include:

1. Surveillance, prevention, and control of infection;
2. Storage and maintenance of sterile supplies and equipment; and
3. Disposal of waste, including blood and body fluid.

B. The administrator shall ensure that housekeeping and maintenance services are provided to maintain a safe and sanitary environment.

C. The administrator shall ensure that equipment is operational and inspected in accordance with the facility's policies and procedures, which shall include the following:

1. Testing, calibrating, servicing, or repairing of equipment to ensure that the equipment is free from fire and electrical hazards; and
2. Maintaining records documenting the service and calibrating performed.

D. Staff shall use, maintain, and store oxygen and other flammable gasses in accordance with A.A.C. R9-1-412(B).

E. Staff shall use and maintain electrical equipment in accordance with A.A.C. R9-1-412(E).

F. The facility shall pass annual inspection for fire safety by the fire authority having jurisdiction.

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1).

R9-10-1411. Emergency Standards

A. The governing authority shall adopt policies and procedures which establish the extent of emergency treatment to be performed within the facility including:

1. Basic life support procedures, and
2. Transfer arrangements for patients who require care above recovery care services.

B. Staff shall provide emergency treatment according to the facility's policies and procedures.

C. The administrator shall ensure the development of a written disaster plan of operation with procedures to be followed in the event of threat to patient safety.

D. The administrator shall ensure disaster drills are conducted on each shift every three months.

E. The administrator shall retain records of disaster drills for 1 year and include the date, time, and critique of the drill.

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1).

R9-10-1412. Physical Plant Requirements

A. Facilities licensed prior to January 1, 1992, shall conform to the requirements of A.A.C. R9-1-412(B), Life Safety Code, Chapter 13, "Existing Health Care Occupancies".

B. Facilities licensed after January 1, 1992, shall conform to the physical plant health and safety codes and standards referenced in A.A.C. R9-1-412.

C. Patient rooms and service areas shall comply with the requirements of A.A.C. R9-1-412(F), Guidelines for Construction and Equipment of Hospital and Medical Facilities, specifically Chapter 7, Sections 7.2(A) and (B) for General Hospitals.

D. Bed capacity shall not exceed two beds per room.

Historical Note

Adopted effective February 1, 1994 (Supp. 94-1).

Editor's Note: The following Article was repealed under an exemption from the provisions of the Administrative Procedure Act which means these rules were not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on the repealing of these rules.

ARTICLE 15. REPEALED

Editor's Note: The following Section was adopted and subsequently repealed under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on the rule; and the Attorney General has not certified this rule.

R9-10-1501. Repealed

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act

pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was adopted and subsequently repealed under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on the rule; and the Attorney General has not certified this rule.

R9-10-1502. Repealed

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Exhibit was adopted and subsequently repealed under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on the rule; and the Attorney General has not certified this rule.

Exhibit A. Repealed

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was adopted and subsequently repealed under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on the rule; and the Attorney General has not certified this rule.

R9-10-1503. Repealed

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was adopted and subsequently repealed under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on the rule; and the Attorney General has not certified this rule.

R9-10-1504. Repealed

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

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R9-10-1505. Repealed

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

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R9-10-1506. Repealed

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective

November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was adopted and subsequently repealed under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on the rule; and the Attorney General has not certified this rule.

R9-10-1507. Repealed

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was adopted and subsequently repealed under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on the rule; and the Attorney General has not certified this rule.

R9-10-1508. Repealed

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, § 3(B). Amended effective May 2, 1997, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1996, Ch. 329, § 5 (Supp. 97-2). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was adopted and subsequently repealed under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on the rule; and the Attorney General has not certified this rule.

R9-10-1509. Repealed

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was adopted and subsequently repealed under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on the rule; and the Attorney General has not certified this rule.

R9-10-1510. Repealed

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was adopted and subsequently repealed under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on the rule; and the Attorney General has not certified this rule.

R9-10-1511. Repealed

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was adopted and subsequently repealed under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on the rule; and the Attorney General has not certified this rule.

R9-10-1512. Repealed

Historical Note

Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was adopted and subsequently repealed under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the

Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on the rule; and the Attorney General has not certified this rule.

R9-10-1513. Repealed

Historical Note
Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

Editor's Note: The following Section was adopted and subsequently repealed under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on the rule; and the Attorney General has not certified this rule.

R9-10-1514. Repealed

Historical Note
Adopted effective August 6, 1993, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1993, Ch. 163, Section 3(B). Repealed effective November 1, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to Laws 1998, Ch. 178, § 17; filed with the Office of the Secretary of State October 2, 1998 (Supp. 98-4).

ARTICLE 16. RESERVED

ARTICLE 17. OUTPATIENT SURGICAL CENTERS

R9-10-1701. Definitions

In this Article, unless the context otherwise requires:

1. "Advance directives" means a living will, prehospital medical care directive, or health care power of attorney.
2. "Circulating nurse" means a licensed nurse who is responsible for the functioning of the operating room during a surgical procedure and who does not directly assist the surgeon.
3. "Inpatient care" means postsurgical services provided in a hospital as defined in Article 2.
4. "Licensed nurse" means an individual licensed pursuant to A.R.S. Title 32, Chapter 15.
5. "Medical staff" means physicians, podiatrists, dentists, and other practitioners licensed pursuant to A.R.S. Title 32 and who are privileged by agreement with the facility, as defined in the facility's medical staff bylaws, to attend patients.
6. "Outpatient surgical services" means those anesthesia and surgical services provided to a patient in an outpatient surgical center which do not require planned inpatient care following a surgical procedure.
7. "Patient's representative" means either a person acting on behalf of a patient with the written consent of the patient or the patient's legal guardian, or a surrogate pursuant to A.R.S. § 36-3201(13).
8. "Surgical suite" means an area which includes 1 or more operating rooms and 1 or more recovery rooms.

Historical Note
Adopted effective July 6, 1994 (Supp. 94-3).

R9-10-1702. Administration

A. The governing authority shall consist of 1 or more persons responsible for the organization and administration of the outpatient surgical center. The governing authority shall:
1. Adopt policies and procedures for the operation of the surgical center to ensure compliance with state laws, rules, and local ordinances;
2. Adopt the medical staff bylaws;
3. Grant or deny clinical privileges of physicians and other members of the medical staff and delineate, in writing, the clinical privileges of each medical staff member; and
4. Adopt a quality management plan.

B. The governing authority shall appoint an administrator who shall have authority and responsibility to manage the facility. The administrator shall:
   a. Be responsible to the governing authority;
   b. Act as a liaison between the governing authority, medical and facility staff;
   c. Develop and implement written administrative policies and procedures governing:
      i. Personnel employment, orientation, in-service, staffing, and recordkeeping;
      ii. Patient admissions, rights and responsibilities, grievances, medical treatment, and recordkeeping;
      iii. Advance directives;
      iv. Medications procurement and dispensing;
      v. Contract services;
      vi. Infection control, housekeeping, and maintenance;
      vii. Quality management and recordkeeping;
      viii. Emergency treatment and disaster plan; and
      ix. Equipment inspection.
   d. Ensure that all the policies and procedures are available to all employees in the facility;
   e. Develop and implement a quality management plan;
   f. Employ personnel to provide outpatient surgical services;
   g. Ensure that a pharmacy maintained by the facility shall be registered pursuant to A.R.S. Title 32, Chapter 18 or as otherwise provided by law;
   h. Ensure that pathology services are provided by a laboratory licensed, or exempt from licensure, pursuant to A.R.S. Title 36, Chapter 4.1; and
   i. Designate, in writing, an individual to be on duty, in charge, and have access to all areas related to patient care and operation of the physical plant when the administrator is not present.

Historical Note
Adopted effective July 6, 1994 (Supp. 94-3).

R9-10-1703. Patient Rights

A. The administrator shall give each patient or patient's representative a written list of patient rights prior to services being provided. The patient or patient's representative shall acknowledge, in writing, receipt of the list of patient rights.

B. The administrator shall post a list of patient rights in a conspicuous area.

C. Personnel shall apprise each patient or patient's representative of the following rights and shall make a reasonable effort to ensure that language barriers or physical handicaps do not prevent each patient or patient's representative from becoming aware of these rights:

1. To be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care needs;
2. To be free from chemical, physical, and psychological abuse or neglect;
3. To refuse or withdraw consent for treatment or give conditional consent for treatment;
4. To have medical and financial records kept in confidence and the release of such records shall be by written consent of the patient or the patient's representative except as otherwise required or permitted by law;
5. To be informed of the following:
   a. Proposed surgical procedures and the risks involved;
   b. Policy on advance directives;
   c. Costs of services prior to obtaining services or prior to a change in rates, charges, or services;
   d. Notice of third-party coverage, including Medicare and Arizona Health Care Cost Containment System coverage; and
   e. The patient grievance process.

Historical Note
Adopted effective July 6, 1994 (Supp. 94-3).

R9-10-1704. Personnel

A. The administrator shall ensure that personnel are employed to meet the needs of patients and that job descriptions which define qualifications, duties, and responsibilities are established for all personnel.

B. Personnel, prior to being employed and annually thereafter, shall submit 1 of the following as evidence of freedom from pulmonary tuberculosis:
1. A report of a negative Mantoux skin test taken within six months of submitting the report, or
2. A written statement from a physician stating that, upon an evaluation of a positive Mantoux skin test taken within six months of submitting the physician's statement or a history of a positive Mantoux skin test, the individual was found to be free from tuberculosis.

C. The administrator shall provide orientation to each employee within the first week of employment. Orientation shall be specific to the position held by the employee.

D. Employees who provide direct patient care shall:
1. Be 18 years of age or older;
2. Be certified in cardiopulmonary resuscitation within the first month of employment, and maintain current certification thereafter; and
3. Attend six hours of in-service education per year which is exclusive of orientation, and cardiopulmonary resuscitation and relates to the purposes and function of an outpatient surgical center.

E. The administrator shall ensure that personnel records are maintained which include:
1. Application for employment;
2. Verification of training, certification, or licensure;
3. Initial proof of freedom from tuberculosis and annual verification statement thereafter; and
4. Orientation and in-service training records.

Historical Note
Adopted effective July 6, 1994 (Supp. 94-3).

R9-10-1705. Medical Staff

A. The medical staff shall approve bylaws for the conduct of medical staff activities.

B. The medical staff physicians shall conduct medical peer review pursuant to A.R.S. Title 36, Chapter 4, Article 5 and shall submit recommendations to the governing authority for approval.

C. The medical staff shall establish written policies and procedures which define the extent of emergency treatment to be performed in the facility including cardiopulmonary resuscitation procedures and provisions for the emergency transfer of a patient.

Historical Note
Adopted effective July 6, 1994 (Supp. 94-3).

R9-10-1706. Nursing Services

A. The administrator shall employ a registered nurse as the director of nursing who shall be responsible for the management and supervision of nursing services, including:
1. Developing and implementing written nursing and patient care policies and procedures, including medications administration, storage, and disposal;
2. Ensuring that the facility is staffed based on the number of patients and their health care needs;
3. Participating in quality management activities; and
4. Appointing a registered nurse, in writing, to act in the absence of the director of nursing.

B. A licensed nurse shall function as a circulating nurse during each surgical procedure.

C. A registered nurse shall be present in the recovery room whenever patients are in the recovery room. A registered nurse shall be in the facility until all patients are discharged.

D. A licensed nurse shall ensure that the patient or patient's representative acknowledges, in writing, the physician's written discharge instructions.

Historical Note
Adopted effective July 6, 1994 (Supp. 94-3).

R9-10-1707. Admission

A. A medical staff physician shall admit patients to the facility who do not require planned inpatient care and who shall be kept in the facility less than 24 hours.

B. Within 30 days prior to admission, a medical staff member shall complete a medical history and physical examination of the patient. The individual responsible for performing the operative procedure shall document the preoperative diagnosis and the procedure to be performed.

C. The administrator shall ensure that the following documents are in the patient's medical record prior to surgery:
1. A medical history and results of a current physical examination,
2. A preoperative diagnosis and the results of any laboratory tests or procedures relative to the surgery and the condition of the patient,
3. Evidence of informed consent by the patient or patient's representative for the surgical procedure and care of the patient,
4. Documentation concerning advance directives, and
5. Physician orders.

Historical Note
Adopted effective July 6, 1994 (Supp. 94-3).

9-10-1708. Quality Management

A. The administrator shall establish and implement a quality management plan that monitors and evaluates the provision of all aspects of patient care including physician and contracted services.

B. The quality management plan shall be in writing and describe the objectives, organization, scope, and process for improving quality of care which shall include the monitoring activities.

C. The administrator shall maintain a record of quality management activities and ensure that any conclusions and recommendations on findings of quality management activities are reported to the governing authority.

Historical Note
Adopted effective July 6, 1994 (Supp. 94-3).

R9-10-1709. Surgical Services Requirements

A. The administrator shall ensure there is a current listing of all surgical procedures offered by the facility and shall maintain a chronological register of all surgical procedures performed.
B. The administrator shall ensure that a roster of medical staff who have surgical or anesthesia privileges at the facility is available to the facility staff, specifying the privileges and limitations of each person on the roster.
C. The individual responsible for performing the operative procedure shall complete an operative report and any necessary discharge instructions according to medical staff bylaws and facility policies and procedures. The individual responsible for the administration of anesthesia shall complete an anesthesia report and any necessary discharge instructions according to medical staff bylaws and facility policies and procedures.
D. A physician shall remain on the premises until all patients are discharged from the recovery room.

Historical Note
Adopted effective July 6, 1994 (Supp. 94-3).

R9-10-1710. Medical Records

A. The administrator shall ensure that a medical record is established and maintained for each patient which contains the following information:
1. Name and address of patient and patient's representative,
2. Written acknowledgment of the receipt of patient rights,
3. Documentation of advance directives,
4. Admitting diagnosis,
5. Medical history and physical examination,
6. Laboratory and radiology reports,
7. Consent forms,
8. Physician orders and notations,
9. Surgeon's operative report,
10. Anesthesia report,
11. Nursing care notations,
12. Medications and treatments administered, and
13. Written acknowledgment of receipt of discharge instructions by the patient or patient's representative.

B. Medical and facility staff shall sign with surname and date their entries in a patient's medical record.
C. Staff shall release medical record information only after receiving the patient's or patient representative's written consent, or as otherwise required or permitted by law.
D. The administrator shall ensure that the medical record of a discharged patient is completed within 90 days of the discharge.
E. Medical records shall be retained on-site at the facility, or retrievable by facility staff within two hours of a request, for a period of 1 year from a patient's discharge.
F. The administrator shall ensure that the medical records are maintained for a period of five years, except as provided in A.R.S. § 36-343.
G. If a facility ceases operation, the governing authority shall ensure the preservation of records and notify the Department, in writing, of the location of the records.

Historical Note
Adopted effective July 6, 1994 (Supp. 94-3).

R9-10-1711. Environmental Standards

A. The administrator shall ensure that written infection control policies and procedures are established and implemented for the surveillance, control, and prevention of infection which shall include the following:
1. Sterilization methods;
2. Storage, maintenance, and distribution of sterile supplies and equipment; and
3. Disposal of waste, including blood, body tissue, and fluid.

B. The administrator shall ensure that housekeeping and maintenance services are provided to maintain a safe and sanitary environment.
C. The administrator shall ensure that equipment is operational, inspected, and maintained in accordance with the facility's policies and procedures which shall include the following:
1. Testing, calibrating, servicing, or repairing of equipment to ensure that the equipment is free from fire and electrical hazards;
2. Maintaining records documenting service and calibration information;
3. Use, maintenance, and storage of oxygen and other flammable gases in accordance with A.A.C. R9-1-412(B); and
4. Use and maintenance of electrical equipment in accordance with A.A.C. R9-1-412(E).

D. The administrator shall ensure that there is a functional emergency power source.

Historical Note
Adopted effective July 24, 1978 (Supp. 78-4). Section repealed, new Section adopted effective July 6, 1994 (Supp. 94-3).

R9-10-1712. Emergency Standards

A. Staff shall provide emergency treatment according to the facility's policies and procedures.
B. The administrator shall ensure the development of a written disaster plan of operation with procedures to be followed in the event of a fire or threat to patient safety and shall ensure that an emergency evacuation route is posted in every room where patients may be present, except restrooms.
C. The administrator shall ensure that:
1. Fire drills are conducted every three months and that all staff on duty participate;
2. Records of the drills include the date, time, and critique of the drills; and
3. Records of the drills are maintained for 1 year.

D. The facility shall pass annual inspection for fire safety by the fire authority having jurisdiction.

Historical Note
Adopted effective July 24, 1978 (Supp. 78-4). Section repealed, new Section adopted effective July 6, 1994 (Supp. 94-3).

R9-10-1713. Physical Plant Standards

A. Facilities licensed prior to the adoption of these rules shall conform to the requirements of A.A.C. R9-1-412(B), Life Safety Code, Chapter 13, Existing Health Care Occupancies.
B. Facilities licensed after the adoption of these rules shall conform to the physical plant health and safety codes and standards referenced in A.A.C. R9-1-411 and R9-1-412.
C. The administrator shall ensure that there shall be two recovery beds for each operating room, for up to four operating rooms, whenever general anesthesia is administered. One additional recovery bed shall be required for each additional operating room.

D. Recovery beds or gurneys shall be located in a space which provides for a minimum of 70 square feet per bed, allowing three feet or more between beds and between the sides of a bed and the wall.

E. The administrator may provide recliner chairs in the recovery room area for patients who have not received general anesthesia.

F. The administrator shall ensure that the following shall be available in the surgical suite:

1. Oxygen and the means of administration;
2. Mechanical ventilatory assistance equipment including airways, manual breathing bag, and suction apparatus;
3. Cardiac monitor;
4. Defibrillator; and
5. Cardiopulmonary resuscitation drugs as determined by the facility's policies and procedures.

Historical Note
Adopted effective July 24, 1978 (Supp. 78-4). Section repealed, new Section adopted effective July 6, 1994 (Supp. 94-3).

R9-10-1714. Reserved

R9-10-1715. Repealed

Historical Note
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1716. Repealed

Historical Note
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1717. Repealed

Historical Note
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1718. Repealed

Historical Note
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1719. Repealed

Historical Note
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1720. Repealed

Historical Note
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1721. Repealed

Historical Note
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1722. Repealed

Historical Note
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1723. Repealed

Historical Note
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1724. Reserved

R9-10-1725. Reserved

R9-10-1726. Reserved

R9-10-1727. Reserved

R9-10-1728. Reserved

R9-10-1729. Reserved

R9-10-1730. Reserved

R9-10-1731. Repealed

Historical Note
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1732. Repealed

Historical Note
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1733. Repealed

Historical Note
Adopted effective July 24, 1978 (Supp. 78-4). Corrections: R9-10-1733(B)(2), correction in spelling, "architectural"; R9-10-1733(C)(1)(d), 100 square feet, corrected to read "1000" square feet, as certified effective July 24, 1978 (Supp. 87-2). Repealed effective July 6, 1994 (Supp. 94-3).

R9-10-1734. Repealed

Historical Note
Adopted effective July 24, 1978 (Supp. 78-4). Repealed effective July 6, 1994 (Supp. 94-3).

TITLE 9. HEALTH SERVICES

CHAPTER 11. DEPARTMENT OF HEALTH SERVICES HEALTH CARE INSTITUTIONS: RATES AND CHARGES

Chapter 11, consisting of Article 1 (Sections R9-11-101 through R9-11-109) and Article 2 (Sections R9-11-201 and R9-11-202) adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2. ***Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules. Because this Chapter contains rules which are exempt from the regulator rulemaking process, the Chapter is being printed on blue paper.***

Chapter 11, consisting of Article 1 (Sections R9-11-101 through R9-11-121), Article 2 (Sections R9-11-201 through R9-11-213), and Article 3 (Section R9-11-301) repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2. ***Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is being printed on blue paper.***

ARTICLE 1. GENERAL

Article 1, consisting of Sections R9-11-101 through R9-11-109, adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Article 1, consisting of Sections R9-11-101 through R9-11-121, repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Section

R9-11-101. Definitions
R9-11-102. Annual filing of operating statements and reports
R9-11-103. Filing of rates and charges
R9-11-104. Filing for review of proposed rate increases -- hospitals
R9-11-105. Financial report for hospital rate changes; preparation and filing instructions
R9-11-106. Filing for review of proposed rate increases - nursing care institutions
R9-11-107. Financial report for nursing care institution rate changes; preparation and filing instructions
R9-11-108. Notification to payers of residents of rate changes proposed by nursing care institutions
R9-11-109. Hearing process for nursing care institutions implementing rate increases
R9-11-110. Repealed
R9-11-111. Repealed
R9-11-112. Repealed
R9-11-113. Repealed
R9-11-114. Repealed
R9-11-115. Repealed
R9-11-116. Repealed
R9-11-117. Repealed
R9-11-118. Repealed
R9-11-119. Repealed
R9-11-120. Repealed
R9-11-121. Repealed

ARTICLE 2. UNIFORM ACCOUNTING SYSTEM

Article 2, consisting of Sections R9-11-201 and R9-11-202, adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Article 2, consisting of Sections R9-11-211 through R9-11-213, repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Section

R9-11-201. Uniform accounting -- Hospitals
R9-11-202. Uniform Accounting -- Nursing Care Institutions
R9-11-203. Reserved
R9-11-204. Reserved
R9-11-205. Reserved
R9-11-206. Reserved
R9-11-207. Reserved
R9-11-208. Reserved
R9-11-209. Reserved
R9-11-210. Reserved
R9-11-211. Repealed
R9-11-212. Repealed
R9-11-213. Repealed

ARTICLE 3. HOSPITAL DISCHARGE REPORTING FOR INPATIENTS

Article 3, consisting of Section R9-11-301 and R9-11-302, adopted effective February 22, 1995, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1994, Ch. 115, § 9 (Supp. 95-1).

Article 3, consisting of Section R9-11-301, repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Section

R9-11-301. Definitions
R9-11-302 Reporting Requirements
TABLE 1. Magnetic Tape Submission - Required Data Items and Formal Specifications for Inpatient Discharges

ARTICLE 1. GENERAL

Editor's Note: The following Section was repealed and a new Section adopted under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council

for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-101. Definitions

A. "Accrual" means recording revenues and expenses when incurred with specific periods of time, such as a month or year, without regard to the date of receipt or payment of cash.

B. "Affiliated Organization" means the same as "related party".

C. "Annualized" means data for any period adjusted to represent a 12-month time period.

D. "Charge Code" means a numeric or alpha-numeric identifier assigned by the health care institution to a unit of service such as a procedure, test, or commodity for which a separate charge is levied to a patient and used for identification on a patient's itemized bill.

E. "Charity Allowances" means reductions in charges for services made by the health care institution because of the indigence of the patient. This does not include Title XIX Arizona Health Care Cost Containment Service (AHCCCS) or any other third- party payor settlements.

F. "Department" or "DHS" means the Department of Health Services.

G. "Direct costs" means those costs which are incurred by and charged directly to the revenue-producing departments of the institution.

H. "Director" means the Director of the Department.

I. "Durable Medical Equipment" means reusable equipment a health care institution makes available for patient services. The equipment can be sold, rented or furnished at no cost to a patient.

J. "Expendable" means those non-reusable commodities that may be sold to and are consumed by the patient.

K. "Formula" means a defined mathematical progression applied to the cost of a product to calculate a patient charge.

L. "Health care institution" or "institution" means every place, building or agency, whether organized for profit or not, which provides medical services, nursing services, or health-related services, except those institutions exempted by A.R.S. § 36-402.

M. "Indirect costs" means those costs which are incurred by and charged directly to the non-revenue-producing departments and then are proportionately allocated to the revenue-producing departments of the institution.

N. "Inpatient hospice" means a hospice licensed by the Department pursuant to A.R.S. §§ 36-405, 36-422 and A.A.C. Title 9, Chapter 10, Article 8 providing 24-hour inpatient care.

O. "Level of Care" means categorizing patient services according to the type of care provided by the health care institution. Patient care factors, such as nursing hours, physical assistance or administration of medications, may be assigned numeric values generating accumulated or weighted points used to apply charges.

P. "Managed Care" means services delivered to clients through a health maintenance organization, preferred provider organization, third-party administrator or an independent physician association.

Q. "Material" means a significant change in revenue or expense in relation to total revenue or significant changes that affect how a facility is managed or controlled.

R. "Natural Classification" means the classification of expenses as reported on the income statement; i.e., the nature of the items as accrued, such as, salaries/wages, benefits, supplies, purchased services, insurance, and depreciation.

S. "Nonexpendable" means those reusable items that may be rented or sold to the patient. This may include durable medical equipment.

T. "Pass through" means any outside service or purchased commodity that is charged to a patient at the health care institution's cost.

U. "Private payor" means an individual or insurance company responsible for the payment of services. Third-party government payor programs are not considered private payors.

V. "Rate or Charge" means a separate dollar amount levied to a patient for use or consumption of a unit of service or commodity.

W. "Related Party" means an investor (individual, partner or corporation) having more than 5% ownership of another entity.

X. "Senior Plan" means contracted managed care services that are an alternate method of delivering services to Medicare-eligible clients.

Y. "Service" means a unit of care such as a procedure, test, or commodity for which a separate rate or charge is made to a patient.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed and a new Section adopted under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-102 Annual Filing of Operating Statements and Reports

A. Every hospital, nursing care institution and inpatient hospice shall submit to the Director not later than 120 days following the institution's fiscal year end the following statements and reports for the reporting year:

1. Hospitals shall file:
   a. A report of an audit by an independent certified public accountant conducted in accordance with generally accepted auditing standards in the format defined in A.R.S. § 36-125.04(B).
   b. A copy of the hospital's annual Medicare Cost Report.
   c. A copy of the uniform accounting report pursuant to R9-11-201.
2. Nursing care institutions (NCI) shall submit a completed Arizona Reporting System for Nursing Institutional Costs (ARSNIC) forms set as their uniform accounting report, and a copy of the annual Medicare Cost Report. The ARSNIC report shall be submitted to the Department in electronic and paper copy format.
3. Inpatient Hospice: Revenue, patient statistics, and expenses related to operating an inpatient hospice shall be delineated either in the Medicare Cost Report for Hospitals or ARSNIC for Nursing Care Institutions.

B. The Director may grant a 30-day extension in writing in advance of the due date of any required reports. The health care facility shall request such extension in writing at least 30

days prior to the due date pursuant to A.R.S. § 36.125.04. The request for extension of time shall include the following:

1. Name and address of the facility,
2. Reason for the request,
3. Requested due date,
4. Name(s) of the operating statements or reports for which an extension is being requested.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

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R9-11-103. Filing of Rates and Charges

A. Each hospital, nursing care institution, supervisory care facility, and home health agency shall file with the Department all schedules of rates or charges, and other information specified in subsection (F) of this rule. This information shall be regarded as the existing schedule of rates or charges for such institutions.

B. A new hospital, nursing care institution, supervisory care facility or home health agency shall not engage in business within this state until its schedule of rates or charges has been filed with the Department and reviewed as provided in A.R.S. § 36-436 et. seq.

C. No rate or charge for a new service or procedure shall be implemented by a hospital or nursing care institution until the requirements of A.R.S. § 36-421 and § 36-436 have been completed in accordance with the following:

1. Rates or charges for a new service or procedure not requiring a permit pursuant to A.R.S. § 36-421 shall be filed with the Director and accompanied by a per-unit cost analysis using direct expense by natural classification, and number of units anticipated over a 12-month period. The Director may issue written findings. Upon submission of all required information, rates will be effective no later than 60 days subsequent to the filing. A schedule of rates and charges for a new service not requiring a permit shall be submitted no more than once quarterly.
2. Rates or charges for a new service or procedure requiring a permit pursuant to A.R.S. § 36-421 shall be accompanied by an analysis consisting of two consecutive 12-month periods projecting each of the following elements:
   a. Volume in units,
   b. Gross Revenue,
   c. Deductions from Revenue,
   d. Direct expenses by natural classification, and
   e. Indirect expenses.

D. No decrease or deletion shall be made by any hospital or nursing care institution in any rate or charge until the proposed decrease or deletion has been filed for informational purposes with the Director.

E. Supervisory care and home health agencies shall submit to the Department increases in rates or charges 30 days prior to implementation.

F. All schedules of rates or charges required to be filed shall include each service and item for which a separate charge is made. The schedule of rates or charges must contain the following information:

1. Facility License Number;
2. Facility Name;
3. Table of contents or record layout that defines the order or sort of the information that would enable the Department to easily locate items by charge code within each department;
4. Department Name and Number;
5. Charge Code;
6. Service description;
7. Existing Charge;
8. Proposed Charge;
9. A copy of all rules, criteria and discounts, such as acuity methodology, pricing rationale, and formulae which may in any way change, affect or determine any part of the aggregate of the rates or charges therein or the value of the services or commodities covered by the schedule.

G. The schedule of rates or charges may be submitted in an electronic format if written approval has been granted by the Department prior to submission.

H. Charges for expendable items received from an outside supplier (excluding capital items for which the patient does not acquire ownership), which are generally numerous in quantity and subject to frequent cost changes, such as pharmacy or central supply items, may be listed on the schedule of rates and charges in the form of a formula, provided that the formula is adopted as a rule or regulation of the institution. The formula shall include, but is not limited to, the following elements:

1. The net purchase cost of the item, which shall reflect all invoiced discounts, allowances or rebates.
2. The percent of cost or dollar markup.

I. If the formula method of listing rates and charges is used, the institution is not required to report or file those rate changes resulting exclusively from a change in the net purchase cost of the item to the institution. Any change in other elements of the formula shall constitute a change in the rate schedule and will require filing of the proposed new rate as provided in A.R.S. § 36-436.02 and 36-436.03.

J. If a charge is priced for outside services rendered by those individuals licensed pursuant to A.R.S. Title 32 or facilities licensed pursuant to A.R.S. Title 36, Article 4, the schedule of rates and charges shall include the pricing policy or formula.

K. The effective date of a proposed schedule of rates or charges of a new institution or of a change in the schedule of rates or charges of an existing institution shall be as determined by the institution but not earlier than:

1 The date of the findings of the Director, or
2 Sixty days after the date of filing the proposed schedule together with all supporting data required by A.R.S. § 36-436 and subsections (F) through (J) of this Section, whichever occurs first.

L. The filing date shall be determined by the Department as defined in R9-11-105 and R9-11-107.

M. If increased rates or charges are not reflected on the patient bills along with discounts, if any, within 30 days after the review period has expired, the institution abandons its right to implement the increased schedule of rates or charges unless written consent is granted by the Director prior to the expiration of the 30-day period.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed and a new Section adopted under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-104. Filing for Review of Proposed Rate Increases -- Hospitals

A. Hospitals shall submit a completed Form 301 (Exhibit 1) as revised June 1, 1993, which is incorporated by reference herein, does not contain any later amendments or editions, and is on file with the Office of the Secretary of State.

B. A hospital may apply in writing to the Department for a waiver from completing Form 301. The hospital shall document in the application that the following apply:
1. Common ownership is shared with another Arizona licensed facility.
2. The hospital has been approved by the Health Care Financing Administration for one Medicare provider number or revenue and expenses are reported as a subprovider on the Medicare Cost Report of the related facility.
3. The hospitals share a common charge master.

C. Each waiver granted under subsection (B) may be revoked by the Director when the Department determines that material changes have occurred which merit separate reporting. Judgments as to materiality shall be based on the Department's knowledge of the hospital. The Department shall notify the hospital in writing of the waiver revocation 120 days prior to the end of the hospital's fiscal year.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed and a new Section adopted under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-105. Financial Report for Hospital Rate Changes; Preparation and Filing Instructions

A. Form 301 shall be prepared and filed with the Department by hospitals proposing increases in rates and charges pursuant to A.R.S. § 36-436.

B. No proposed rates shall be charged to patients until the Director has issued findings on the proposed increase or 60 days have elapsed from the date of a complete filing, whichever occurs first.

C. A complete rate package shall include:
1. A complete and accurate Form 301.
2. A schedule of the rates and charges as defined in R9-11-103.
3. Written justification for a rate increase and the planned date of implementation.
4. The pricing policy of the hospital for establishing rates.
5. The hospital cost containment program for the Projected Year and a quantified estimate of economic savings for the Base Year.
6. Financing information or a prospectus and applicable debt retirement schedules, if new debt has been incurred or the current debt has been refinanced since the last rate review filing.
7. A copy of the current management agreement and lease, if applicable.
   a. Details of management fees or corporate cost allocations from a home office including the allocation or charge methodology for each function or service.
   b. Details of lease expenses paid to a related party for property, plant and equipment, submitted with Form 301 in a supplemental schedule which shall include cost, depreciation basis, debt amortization (interest expense and principal payments) for the applicable assets.

D. All required reports and documents pursuant to A.R.S. § 36-125.04 and A.A.C. R9-11-102 and R9-11-105(C) shall be complete and on file with the Department before a filing date is established. Incomplete reports shall not be accepted unless prior written approval to omit specified information has been obtained from the Department. Form 301 shall not be considered as filed, and the 60-day review period shall not commence, until receipt of all required information.
1. Information may be requested by the Department after the initial review of the application in order to clarify any financial or statistical data contained in the rate package.
2. The 60-day review period shall begin from the most recent submission date if the information submitted by the institution at the Department's request or submitted due to revisions initiated by the institution, results in any of the following for the Base Year or Projected Year:
   a. A modification to the schedule of proposed rates and charges.
   b. A change in annual revenue that exceeds 0.5% of the original submittal.
   c. A change in annual operating expense that exceeds 0.5% of the original submittal.
   d. A modification of the Statement of Cash Flows.

E. The following instructions shall apply to the preparation of Form 301:
1. Each hospital shall submit a completed Form 301 to the Department in an electronic format supplied by the Department.
2. If schedules or sections are not applicable, those lines should be left blank. Any or all items left blank are subject to the approval of the Department.
3. No printed line item descriptions, titles, or column headings shall be altered or changed.
4. An institution may supplement Form 301 with additional information necessary to justify the proposed increase.
5. Financial amounts shall be rounded to the nearest dollar amount.

6. If the date of the filing is within the first six months of the institution's current fiscal year, the following reporting periods shall apply:
   a. "Base Year" means the fiscal year immediately preceding the filing date predicated on actual information, plus the estimated results for the balance of the year, if applicable.
   b. "Prior Year" means the fiscal year immediately preceding the "Base Year" predicated on actual information.
   c. "Projected Year" means the current fiscal year predicated on actual year-to-date information, plus the projected results for the balance of the year.
7. If the date of the filing is within the last six months of the institution's current fiscal year, the following reporting periods shall apply:
   a. "Base Year" means the current fiscal year predicated on actual year-to-date information, plus the estimated results for the balance of the year.
   b. "Prior Year" means the fiscal year immediately preceding the "Base Year" predicated on actual information.
   c. "Projected Year" means the fiscal year subsequent to the "Base Year" predicated entirely on projected results.

F. When completing Form 301, the hospital shall define any cost center descriptions added in the space provided or group the cost center on a line item with the same unit of measure.

G. The hospital shall report the number of units of service and the definition of each unit by revenue center. The hospital must obtain prior written permission from the Department to use a definition for a unit of service that is different than those listed in Schedule 14 and 15 of Form 301, or to change their definition of a unit of service in any revenue center between reporting periods.

H. For any patient care services provided in alternate areas, the patient days, revenues and costs shall be reclassified to the responsible unit prior to preparing Form 301.

I. The financial and statistical information reported in Form 301 shall be reported on the accrual basis of accounting.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed and a new Section adopted under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-106. Filing for Review of Proposed Rate Increases - Nursing Care Institutions

Nursing Care Institutions shall submit a completed Form 302 (Exhibit 2) as revised June 1, 1993, which is incorporated by reference herein, does not contain any later amendments or editions, and is on file with the Office of the Secretary of State.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed and a new Section adopted under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-107. Financial Report for Nursing Care Institution Rate Changes; Preparation and Filing Instructions

A. Form 302 shall be prepared and filed by all Nursing Care Institutions (NCI) proposing increases in rates and charges.

B. A hospital based NCI, licensed for 60 beds or less, may apply in writing to the Department for a waiver from completing Form 302. The waiver request shall be submitted prior to proposing an increase in rates and charges of the NCI. The hospital based NCI shall document in the application that the following apply:
1. The NCI is separated from the hospital campus by no more than one common public or private thoroughfare;
2. The hospital includes the NCI as a discrete operating department in the Financial Report for Review of Proposed Rate Increases -- Hospitals, Form 301; and
3. The NCI charges are included in the hospital's charge master.

C. No proposed rate shall be charged to patients until the Director has issued findings on the proposed increase, or 60 days have elapsed from the date of a completed filing, as determined by the Department, whichever occurs first.

D. A complete rate package shall include:
1. A complete and accurate Form 302.
2. Schedule of current and proposed rates and charges for all services rendered to patients according to the NCI's level of care definitions together with a copy of the rules and criteria as defined in R9-11-103.
3. Written justification for a rate increase and the planned date of implementation.
4. A copy of the current management agreement and lease, if applicable.
   a. Detail of management fees and corporate cost allocations charged from a home office including the methodology used to determine the allocations and fees.
   b. Details of lease expense paid to a related party for property, plant and equipment, submitted with Form 302 in a supplemental schedule which shall include cost, depreciation basis, debt amortization (interest expense and principle payments) for the applicable assets.

E. All required reports and documents pursuant to A.R.S. § 36-125.04 and A.A.C. R9-11-107(D) shall be complete and on file with the Department before a filing date is established. Incomplete reports shall not be accepted unless prior written approval to omit specified information has been obtained from the Department. Form 302 shall not be considered as filed, and the 60-day review period shall not commence, until receipt of all the required information.

1. Information may be requested by the Department after the initial review of the application in order to clarify any financial or statistical data contained in the rate package.
2. The 60-day review period shall begin from the most recent submission date if the information submitted by the institution at the Department's request or submitted due to revisions initiated by the institution, results in any of the following for the Base Year or Projected Year:
   a. A modification to the schedule of proposed rates and charges.
   b. A change in annual revenue that exceeds 0.5% of the original submittal.
   c. A change in annual operating expense that exceeds 0.5% of the original submittal.
   d. A modification of the Statement of Cash Flows.

F. The following general instructions apply to the preparation of Form 302:
1. Each NCI shall submit a completed Form 302 to the Department in an electronic format supplied by the Department and a printout of the report. A manual Form 302 shall be accepted in lieu of an electronic format.
2. If schedules or sections are not applicable, those lines should be left blank. Any or all items left blank are subject to the approval of the Department.
3. No printed line item descriptions, titles, or column headings shall be altered or changed.
4. An institution may supplement Form 302 with additional information necessary to justify the proposed increase.
5. Financial amounts shall be rounded to the nearest dollar amount.
6. If the date of the filing is within the first six months of the institution's current fiscal year, the following reporting periods shall apply:
   a. "Base Year" means the fiscal year immediately preceding the filing date predicated on actual information, plus the estimated results for the balance of the year, if applicable.
   b. "Prior Year" means the fiscal year immediately preceding the "Base Year" predicated on actual information.
   c.. "Projected Year" means the current fiscal year predicated on actual year-to-date information, plus the projected results for the balance of the year.
7. If the date of the filing is within the last six months of the institution's current fiscal year, the following reporting periods shall apply:
   a. "Base Year" means the current fiscal year predicated on actual year-to-date information, plus the estimated results for the balance of the year.
   b. "Prior Year" means the fiscal year immediately preceding the "Base Year" predicated on actual information.
   c. "Projected Year" means the fiscal year subsequent to the "Base Year" predicated entirely on projected results.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

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R9-11-108. Notification to Residents of Rate Changes Proposed by Nursing Care Institutions

The nursing care institution shall notify each private payor in writing of changes in either rates or services 60 days prior to the date of implementation of the rates and charges. The notice shall include the following:
1. The proposed implementation date.
2. A rate schedule delineating the current and proposed rates and charges for each type of service.
3. If the proposed rate increase exceeds the health care consumer price index criteria pursuant to A.R.S. §36-436.03(B), the following shall be included:
   a. A statement that the proposed increase exceeds the consumer price index.
   b. A statement in a prominent place that informs the patients of their right to request a public hearing.
   c. The last date that a hearing can be requested per R9-11-109(B).
   d. The Department's current address to which a request for hearing should be sent.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

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R9-11-109. Hearing Process for Nursing Care Institutions Implementing Rate Increases

A. The director shall hold a public hearing when the annualized rate increase exceeds the health care consumer price index criteria pursuant to A.R.S. § 36-436.03, and a person affected by the proposed rate schedule requests a hearing within 30 days of the filing of the proposed rates.

B. When a public hearing has been requested pursuant to A.R.S. § 36-436.03(B), the NCI shall post notice in a prominent place ten days prior to the hearing. The notice shall include the following:
1. A statement of the time and place for the public hearing.
2. A rate schedule delineating the current and proposed rates and charges for all services.
3. A schedule of all matters to be discussed.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

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R9-11-110. Repealed

Historical Note

Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-111. Repealed

Historical Note

Added Regulation 2-74. Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-112. Repealed

Historical Note

Added Regulation 2-74. Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-113. Repealed

Historical Note

Added Regulation 2.74. Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-114. Repealed

Historical Note

Amended effective January 16, 1976 (Supp. 76-1). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-115. Repealed

Historical Note

Repealed effective January 16, 1976 (Supp. 76-1). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-116. Repealed

Historical Note

Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-117. Repealed

Historical Note
Department correction of Form number (Supp. 75-1). Amended effective June 30, 1987 (Supp. 87-2). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-118. Repealed

Historical Note
Department correction of language of Regulation heading, Department correction of subsections (B) through (H) initially this material was available upon request, it is now printed in full (Supp. 75-1). Amended effective June 30, 1987 (Supp. 87-2). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-119. Repealed

Historical Note
Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-120. Repealed

Historical Note
Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-121. Repealed

Historical Note
Department correction of language of regulation heading. Department correction of subsections (B) through (G) initially this materially was available upon request, it is now printed in full (Supp. 75-1). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

ARTICLE 2. UNIFORM ACCOUNTING SYSTEM

Editor's Note: The following Section was repealed and a new Section adopted under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-201. Uniform Accounting -- Hospitals
Each general hospital, special hospital or infirmary licensed by the Department, unless exempt by A.R.S. § 36-125.04(I), shall, for each fiscal year, file a completed Uniform Accounting Report (Exhibit 3) not later than 120 days following the institution's fiscal year end.

Historical Note
Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed and a new Section adopted under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-202 Uniform Accounting -- Nursing Care Institutions
Each nursing care institution shall, for each fiscal year, file a completed Arizona Reporting System for Nursing Institutional Costs (ARSNIC) forms set (Exhibit 4) not later than 120 days following the institution's fiscal year end.

Historical Note
Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

R9-11-203. Reserved

R9-11-204. Reserved

R9-11-205. Reserved

R9-11-206. Reserved

R9-11-207. Reserved

R9-11-208. Reserved

R9-11-209. Reserved

R9-11-210. Reserved

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-211. Repealed

Historical Note

Adopted effective January 16, 1976 (Supp. 76-1). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-212. Repealed

Historical Note

Adopted effective January 16, 1976 (Supp. 76-1). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

Editor's Note: The following Section was repealed under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-11-213. Repealed

Historical Note

Adopted effective January 16, 1976 (Supp. 76-1). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

ARTICLE 3. HOSPITAL DISCHARGE REPORTING FOR INPATIENTS

Editor's Note: The following Section was repealed and a new Section adopted under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules.

R9-11-301. Definitions

In this Article, unless the context otherwise requires:

1. "AHCCCS" means the Arizona Health Care Cost Containment System.
2. "AHCCCS/Medicaid" means care provided pursuant to A.R.S. § 36-2905.
3. "AHCCCS Health Group" means reimbursement for care provided to non-AHCCCS eligible clients but who are enrolled with the AHCCCS through their employer health group plan.
4. "BPI" means bits per inch.
5. "Charity" means reduction in charges for services made by the health care institution because of the indigence of the patient but does not include Title XIX, AHCCCS, contractual obligations of the facility, or other third-party payor settlements.
6. "EBCDIC" means extended binary coded decimal interchange code.
7. "E code" means the environmental events, circumstances, and conditions that caused the injury, poisoning, and other adverse effects.
8. "Foreign national" means reimbursement of a hospital for care provided to another country's national health care system client.
9. "HMO" means a health maintenance organization.
10. "Home IV provider" means individuals or organizations who assist in the delivery of drugs and devices to patients pursuant to A.R.S. Title 32, Chapter 18.
11. "Hospital identification number" means the federal tax identification number.
12. "ICD" means international classification of diseases.
13. "Medicare risk" means contracted services provided by a HMO that represent an alternate method to the federal system of delivering services to individuals 65 and over.
14. "Patient" means a person who is admitted to the hospital as an inpatient only.
15. "Patient certificate/social security number" means an insured's unique identification number utilized by the payer organization.
16. "Patient control number" means the medical record number or other hospital-assigned number for patient identification purposes.
17. "Payer code" means the expected primary source of payment for the majority of the charges associated with treatment.
18. "Physician number" means the state license number of an individual licensed pursuant to A.R.S. Title 32.
19. "PPO" means a preferred provider organization.
20. "Self pay" means payment made directly by the patient, guarantor, relatives, or friends for a patient who does not have medical insurance.
21. "SNF" means a skilled nursing facility pursuant to A.R.S. Title 36, Article 7.

22. "Total patient charges" means the gross charges incurred by a patient that are billed by the hospital.

Historical Note

Adopted effective May 22, 1989 (Supp. 89-2). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2). New Section adopted effective February 22, 1995, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1994, Ch. 115, § 9 (Supp. 95-1).

Editor's Note: The following Section was adopted under an exemption from A.R.S. Title 41, Chapter 6 which means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings on these rules.

R9-11-302. Reporting Requirements

A. Each hospital shall report statistical and demographic information, as specified in subsections (B) through (E), to the Department for each patient discharged by the hospital, in accordance with the following schedule:
1. For each patient discharged between January 1 and June 30, the information shall be submitted by August 15; and
2. For each patient discharged between July 1 and December 31, the information shall be submitted by February 15.

B. Hospitals shall report to the Department the diagnosis, procedures, and revenue codes pertaining to each discharged patient in a uniform format as specified by the UB-92, National Uniform Billing Data Element Specifications, October 8, 1993, Arizona Hospital Association, 1501 West Fountainhead Parkway, Suite 650, Tempe, Arizona 85282, incorporated herein by reference and on file with the Office of the Secretary of State.

C. Hospitals shall submit the following data elements for each discharged patient in accordance with the physical layout in the Table included in this Article:
1. Hospital identification number,
2. Patient control number,
3. Patient certificate/social security number,
4. Patient race,
5. Patient street address,
6. Patient city,
7. Patient state,
8. Patient zip code,
9. Patient date of birth,
10. Patient sex,
11. Patient date of admission,
12. Patient date of discharge,
13. Patient discharge status,
14. Diagnostic related group code,
15. Total patient charges,
16. Payer code,
17. Revenue codes:
    a. All inclusive rate,
    b. Room and board - private,
    c. Room and board - two bed,
    d. Room and board - 3 or 4 bed,
    e. Private (deluxe),
    f. Room and board - ward,
    g. Other room and board,
    h. Nursery,
    i. Intensive Care,
    j. Coronary Care,
    k. Special charges,
    l. Incremental charges,
    m. All inclusive ancillary,
    n. Pharmacy,
    o. IV therapy,
    p. Medical/Surgical supplies,
    q. Oncology,
    r. Durable medical equipment (other than renal),
    s. Laboratory,
    t. Laboratory pathology,
    u. Radiology - diagnostic,
    v. Radiology - therapeutic,
    w. Nuclear Medicine,
    x. CT scan,
    y. Operating room,
    z. Anesthesia,
    aa. Blood,
    bb. Blood storage and processing,
    cc. Other imaging,
    dd. Respiratory services,
    ee. Physical therapy,
    ff. Occupational therapy,
    gg. Speech therapy,
    hh. Emergency room,
    ii. Pulmonary function,
    jj. Audiology,
    kk. Cardiology,
    ll. Osteopathic services,
    mm. Ambulance,
    nn. Medical social services,
    oo. MRI,
    pp. Medical/Surgical supplies (Extension of 27X),
    qq. Drugs requiring specific identification,
    rr. Cast room,
    ss. Recovery room,
    tt. Labor/Delivery,
    uu. EKG/ECG,
    vv. EEG,
    ww. Gastro intestinal services,
    xx. Treatment/observation room,
    yy. Lithotripsy,
    zz. Inpatient renal dialysis,
    aaa. Organ acquisition,
    bbb. Miscellaneous dialysis,
    ccc. Psychiatric treatment,
    ddd. Psychiatric services,
    eee. Other diagnostic services,
    fff. Other therapeutic services,
    ggg. Professional fees (96X),
    hhh. Professional fees (97X),
    iii. Professional fees (98X),
    jjj. Patient convenience items,
    kkk. All other not covered in (a) through (jjj),
18. Physician name,
19. Physician number,
20. Physician licensing board,
21. Other physician name,
22. Other physician number,
23. Other physician licensing board,
24. Type of admission,
25. Source of admission,
26. Principal diagnosis,
27. Second diagnosis,
28. Third diagnosis,
29. Fourth diagnosis,

30. Fifth diagnosis,
31. Sixth diagnosis,
32. Seventh diagnosis,
33. Eighth diagnosis,
34. Ninth diagnosis,
35. External causes of injury (E code),
36. Second external cause of injury (E code),
37. Principal procedure date,
38. Principal procedure,
39. Second procedure,
40. Third procedure,
41. Fourth procedure,
42. Fifth procedure,
43. Sixth procedure, and
44. Newborn birth weight.

D. Hospitals shall provide the information required in subsection (C) to the Department in the following format:

1. Medium - Untitled, 9 track, 1/2 inch tape
2. Bits per inch -6250
3. Record length -694 characters
4. Blocksize -27760 characters
5. Data format -Extended Binary Coded Decimal Interchange Code

E. The Director shall approve an exception to the format described in subsection (D) in accordance with the following:

1. A hospital shall submit a written request to use an alternate format 90 days prior to the next due date.
2. The alternate format shall include:
   a. Name of the software program that the data is to be submitted in, and
   b. A written description of the file layout.
3. The request shall include a test sample of discharge information as specified in subsection (C).
4. The Department shall notify the hospital of its decision not less than 60 days prior to the next due date for filing the report.

F. The Director shall revoke, in writing, 120 days prior to the next submission date, an alternate format granted under subsection (E) when the Department determines that it can no longer convert the submitted information into a usable file format.

Historical Note

Section adopted effective February 22, 1995, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1994, Ch. 115, § 9 (Supp. 95-1).

TABLE 1
MAGNETIC TAPE SUBMISSION
REQUIRED DATA ITEMS AND FORMAT SPECIFICATIONS FOR INPATIENT DISCHARGES

CHARACTERS	POSITION	DATA ELEMENT NAME	UNIFORM BILLING LOCATOR NUMBER	CODES AND VALUES	EDIT REQUIREMENTS
10	1-10	Hospital ID - Federal Tax No	5	Alpha-Numeric	All digits must be filled in. Do not change ID without prior permission from DHS.
17	11-27	Patient's Medical Record Number	23	Alpha-Numeric	Must be filled in. Right justified with leading zeros.
19	28-46	Certificate, Social Security Number, or Health Insurance Claim Number	60	Alpha-Numeric with leading zeros.	Must be filled in. Right justified
1	47	Patient Race	-	Race 1 = American Indian, Aleut, Eskimo 2 = Asian, Pacific Islander 3 = Black 4 = Caucasian, Hispanic 5 = Caucasian, Non Hispanic 6 = Other 9 = Refused	Must be entered.
30	48-77	Patient Street Address	13	Alpha-Numeric	Must be filled in.
20	78-97	Patient City	13	Alpha-Numeric	Must be filled in.
2	98-99	Patient State	13	Alpha-Numeric	Must be filled in.
10	100-109	Patient's Zip Code	13	Alpha-Numeric	Postal zip code for the patient's residence at the time of admission. If zip plus four is used indicate as XXXXX-YYYY. Must be filled in. If a foreign resident, fill in with name of the country.
8	110-117	Patient's Date of Birth	14	Enter month-day-year, without dashes MMDDYYYY	All digits must be filled in. If any portion of birthday is unknown enter all zeros for the birthday.
1	118	Patient's Sex	15	Patient's Sex M = Male F = Female	Must be filled in.
8	119-126	Date of Admission	6	The month, day and year of the patient's admission to the hospital. MM-DD-YY	All digits must be filled in including dashes.
8	127-134	Date of Discharge	6	The month, day, and year of the patient's discharge from the hospital. MM-DD-YY	All digits must be filled in including dashes.

CHARACTERS	POSITION	DATA ELEMENT NAME	UNIFORM BILLING LOCATOR NUMBER	CODES AND VALUES	EDIT REQUIREMENTS
2	135-136	Patient's Discharge Status	22	The circumstances under which the patient left the hospital: 01 = Discharged to home or self care. 02 = Discharged/ transferred to another short-term general hospital. 03 = Discharged/ transferred to skilled nursing (SNF). 04 = Discharged/ transferred to an intermediate care facility (ICF). 05 = Discharged/ transferred to another type of institution. 06 = Discharged/ transferred to home under care of organized home health service organization. 07 = Left against medical advice. 08 = Discharged/ transferred to home under care of a Home IV provider. 20 = Expired. 09 = All Other	Must be filled in. Right justified with a leading zero. Zero if unknown.
3	137-139	DRG Code	78	The condition established after study as being chiefly responsible for the admission of a patient to the hospital for care.	All digits must be filled in. Right justified with leading zeros.
7	140-146	Total Charges	47	The total gross charges incurred by the patient. Hospital charges only.	All digits must be filled in. Right justified with leading zeros. Note, whole dollars only, rounded.
2	147-148	Payer Code	50	The expected source of payment for the majority of the charges associated with this treatment. 00 = Self pay 01 = Commercial (Indemnity) 02 = HMO 03 = PPO 04 = AHCCCS Health Care Group 05 = Medicare	Must be filled in. Right justified with leading zeros.

CHARACTERS	POSITION	DATA ELEMENT NAME	UNIFORM BILLING LOCATOR	CODES AND NUMBER	EDIT REQUIREMENTS VALUES
				06 = AHCCCS/ Medicaid 07 = CHAMPUS/ MEDEXCEL 08 = Children's Rehabilitation Services 09 = Workers' Compensation 10 = Indian Health Services 11 = Medicare Risk 12 = Charity 13 = Foreign National 14 = Other	
6		Revenue Codes	42	Total gross charges for each revenue code.	All digits must be filled in. Right justified with leading zeros. Note, whole dollars only, rounded.
	149-154	All inclusive rate	10x		
	155-160	Room and board - private	11x		
	161-166	Room and board - two bed	12x		
	167-172	Room and board - 3/4 bed	13x		
	173-178	Private (deluxe)	14x		
	179-184	Room and board - ward	15x		
	185-190	Other room and board	16x		
	191-196	Nursery	17x		
	197-202	Intensive Care	20x		
	203-208	Coronary Care	21x		
	209-214	Special charges	22x		
	215-220	Incremental charges	23x		
	221-226	All inclusive ancillary	24x		
	227-232	Pharmacy	25x		
	233-238	IV therapy	26x		
	239-244	Medical, surgical supplies	27x		
	245-250	Oncology	28x		
	251-256	DME (other than renal)	29x		
	257-262	Laboratory	30x		
	263-268	Laboratory pathology	31x		
	269-274	Radiology-diagnostic	32x		
	275-280	Radiology - therapeutic	33x		
	281-286	Nuclear Medicine	34x		
	287-292	CT scan	35x		
	293-298	Operating room	36x		
	299-304	Anesthesia	37x		
	305-310	Blood	38x		
	311-316	Blood storage/ processing	39x		
	317-322	Other imaging	40x		
	323-328	Respiratory services	41x		
	329-334	Physical therapy	42x		
	335-340	Occupational therapy	43x		
	341-346	Speech therapy	44x		
	347-352	Emergency room	45x		

CHARACTERS	POSITION	DATA ELEMENT NAME	UNIFORM BILLING LOCATOR NUMBER	CODES AND VALUES	EDIT REQUIREMENTS
	353-358	Pulmonary function	46x	Total gross charges for each revenue	All digits must be filled in. Right justified with leading zeros. Note, code.whole dollars only, rounded.
	359-364	Audiology	47x		
	365-370	Cardiology	48x		
	371-376	Osteopathic services	53x		
	377-382	Ambulance	54x		
	383-388	Medical social services	56x		
	389-394	MRI	61x		
	395-400	Med/Surg (Ext. of 27x)	62x		
	401-406	Drugs required specific ID	63x		
	407-412	Cast room	70x		
	413-418	Recovery room	71x		
	419-424	Labor / Delivery	72x		
	425-430	EKG / ECG	73x		
	431-436	EEG	74x		
	437-442	Gastro intestinal services	75x		
	443-448	Treatment / observation room	76x		
	449-454	Lithotripsy	79x		
	455-460	Inpatient renal dialysis	80x		
	461-466	Organ acquisition	81x		
	467-472	Miscellaneous dialysis	88x		
	473-478	Psychiatric treatment	90x		
	479-484	Psychiatric services	91x		
	485-490	Other diagnostic services	92x		
	491-496	Other therapeutic services	94x		
	497-502	Professional fees	96x		
	503-508	Professional fees	97x		
	509-514	Professional fees	98x		
	515-520	Patient convenience items	99x		
	521-526	All other		-	
22	527-548	Physician Name	82	Attending physician's name. Last, First, Middle Initial.	Left justified. Use "unknown physician" if unknown.
6	549-554	Physician State License No.	82	Attending physician's or other practitioner's Arizona License Number.	All digits must be filled in. Right justified with leading zeros. Fill with zeros if unknown. Can be Alpha-numeric (locum tenens).
1	555	Licensing Board	-	Board: 1 = Medical Examiners 2 = Dental Examiners 3 = Podiatry Examiners 4 = Osteopathic Examiners 5 = Nursing 9 = Other	Must be filled in.
22	556-577 Name	Other Physician	83	Primary procedure physician's name Last, First, Middle Initial.	Left justified. Use "unknown physician" if unknown.

CHARACTERS	POSITION	DATA ELEMENT NAME	UNIFORM BILLING LOCATOR NUMBER	CODES AND VALUES	EDIT REQUIREMENTS
6	578-583	Other Physician State License No.	83	Physician, or other practitioner's Arizona License Number who performed the primary procedure.	All digits must be filled in. Right justified with leading zeros. Fill with zeros if unknown. Can be Alpha-numeric (locum tenens).
1	584	Licensing Board	-	Board: 1 = Medical Examiners 2 = Dental Examiners 3 = Podiatry Examiners 4 = Osteopathic Examiners 5 = Nursing 9 = Other	Must be filled in.
1	585	Type of Admission	19	Indicates the priority (type) of admission: 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 9 = Information not available	Must be filled in. If 4 (newborn), Source of admission must be 1-4, or 9 (unknown).
1	586	Source of Admission	20	Indicates the source of admission - adults and pediatrics: 1 = Physician referral 2 = Clinic referral 3 = HMO / AHCCCS health plan referral 4 = Transfer from a hospital 5 = Transfer from a SNF 6 = Transfer from another health care facility (other than acute care or SNF) 7 = Emergency room 8 = Court / Law Enforcement 9 = Information not available If **Type of Admission** = newborn (4) use: 1 = Normal Delivery 2 = Premature Delivery 3 = Sick baby 4 = Extramural birth 9 = Information not available	Must be filled in.
6	587-592	Principal Diagnosis Code	67	Enter the ICD code describing the condition chiefly responsible for causing this hospitalization.	Left adjust. Must be filled in, including decimal and applicable letter, such as V or E code. Leave blank if unknown. If code consists of less than 6 places, including the decimal, do not zero fill the blank(s) on the right.

CHARACTERS	POSITION	DATA ELEMENT NAME	UNIFORM BILLING LOCATOR NUMBER	CODES AND VALUES	EDIT REQUIREMENTS
6	593-598	Second Diagnosis Code	68	Enter the ICD code describing additional	Leave blank if not applicable. Otherwise, left adjust, and include decimal and applicable letter such as V or E code. If code consists conditions of less than 6 places, including the decimal, do not zero fill the blank(s) on the right.
6	599-604	Third Diagnosis Code	69	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	605-610	Fourth Diagnosis Code	70	Same as the second diagnosis code.	Same as instructions for the second diagnosis code
6	611-616	Fifth Diagnosis Code	71	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	617-622	Sixth Diagnosis Code	72 second	Same as the code. diagnosis code.	Same as instructions for the second diagnosis
6	623-628	Seventh Diagnosis Code	73	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	629-634	Eight Diagnosis Code	74	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	635-640	Ninth Diagnosis Code	75	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	641-646	External Cause of Injury	77	Enter the ICD code describing the external cause of injury.	Leave blank if not applicable. Otherwise, left adjust, include decimal and the letter E.
6	647-652	Second External Cause of Injury	-	Enter the ICD code describing the external cause of injury.	Leave blank if not applicable. Otherwise, left adjust, include decimal and the letter E.
8	653-660	Principal Procedure Date	80	The month, day, and year of the patient's principal procedure MM-DD-YY	All digits must be filled in including dashes.
5	661-665	Principal Procedure Code	80	Enter the ICD code that dentifies the the principal procedure	Left adjust. Must be filled in, including decimal. Leave blank if unknown. If code consists of less than 5 places, including the decimal, do not zero fill the blank(s) on the right. performed.
5	666-670	Second Procedure Code	81A	Enter the ICD code describing procedures other than the principal procedure.	Leave blank if not applicable. Otherwise left adjust and include decimal. If code consists of less than 5 places including the decimal, do not zero fill the blank(s) on the right.

CHARACTERS	POSITION	DATA ELEMENT NAME	UNIFORM BILLING LOCATOR NUMBER	CODES AND VALUES	EDIT REQUIREMENTS
5	671-675	Third Procedure Code	81B	Same as second procedure code.	Same as instructions for the second procedure code.
5	676-680	Fourth Procedure Code	81C	Same as second procedure code.	Same as second procedure code.
5	681-685	Fifth Procedure Code	81D	Same as second procedure code.	Same as second procedure code.
5	686-690	Sixth Procedure Code	81E	Same as second procedure code.	Same as second procedure code.
4	691-694	Newborn Birth Weight	-	Birth weight in grams.	Must be entered for all newborns.

Data Requirements for Reporting Under A.R.S. § 36-125.05

MEDIUM:	9 TRACK, 1/2 INCH TAPE
BPI:	6250
RECL:	694 CHARACTERS
BLOCKSIZE:	27,760
LABEL:	NO LABELS
DATA FORMAT:	EBCDIC

MAGTAPE.FN2 (2/2/95)

Historical Note

Adopted effective February 22, 1995, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1994, Ch. 115, § 9 (Supp. 95-1).

TITLE 9. HEALTH SERVICES

CHAPTER 12. DEPARTMENT OF HEALTH SERVICES HEALTH CARE SERVICES ORGANIZATIONS

ARTICLE 1. APPROVAL OF PLANS, FACILITIES, PERSONNEL AND SERVICE AREAS

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thru
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ARTICLE 1. APPROVAL OF PLANS, FACILITIES, PERSONNEL AND SERVICE AREAS

R9-12-01. Reserved
thru
R9-12-100. Reserved

R9-12-101. Legal authority

A. The Arizona Department of Health Services, pursuant to the authority granted in Title 20, Chapter 4, Article 9, Arizona Revised Statutes, particularly Sections 20-1053 and 20-1054 as amended, hereby adopts the following regulations for the purposes of establishing minimum standards and procedures for health care plans, facilities, personnel and service areas of health care services organizations.

B. In performing its duties related to health care services organizations, the Department of Health Services will coordinate its efforts with the Arizona Department of Insurance which grants the certificate of authority required to operate a health care services organization in Arizona. A copy of the application for a certificate of authority shall be submitted to the Department of Health Services at the same time that the original application is submitted to the Department of Insurance. A request from an existing health care services organization for approval to change its statement describing its health care plan or plans, facilities, and personnel or its statement describing the geographic area or areas to be served shall be submitted to the Department of Health Services and a copy of the request shall be submitted to the Department of Insurance. The Department of Health Services will notify the applicant or health care services organization of its findings and will provide a copy of its findings to the Department of Insurance.

C. These regulations apply to all proposed and existing health care services organizations. Each proposed health care services organization must meet requirements prior to receiving a certificate of authority from the Department of Insurance. Each existing health care services organization need not refile all information previously filed with the Department or the Department of Insurance, but it shall on or before the effective date of this Article amend its health care plan and otherwise modify its operations and procedures as may be necessary to comply with this Article and file all additional information necessary to make statements complete and current.

Historical Note
Adopted effective August 25, 1975 (Supp. 75-1).

R9-12-102. Intent

A. It is the objective of the Director, in the adoption of the regulations of this Article, to require minimum health care services necessary to maintain persons in good health.

B. It is the intention of the Director to revise these minimum requirements periodically, based on Departmental experience and recommendations, in order that more comprehensive health care may be achieved.

Historical Note
Adopted effective August 25, 1975 (Supp. 75-1).

R9-12-103. Definitions

A. Words defined in A.R.S. §§ 36-401 and 20-1051 (except for the word "Director" which when used in this Article means Director of the Department of Health Services) and Department of Health Services regulations for the licensing of health care institutions (Chapter 10, Article 1), and in Department of Insurance rules for the regulation of health care services organizations (General Rule No. R4-14-405) have the same meaning when used in this Article.

B. In this Article, unless the context otherwise requires:

1. "Chief executive officer" means the person who has the authority and responsibility for the operation of the health care services organization in accordance with applicable legal requirements and policies approved by the governing authority.
2. "Department" means the Department of Health Services.
3. "Governing authority" means the person or body such as the board of trustees or board of directors in whom the ultimate authority and responsibility for the direction of the health care services organization is vested.
4. "HCSO" means health care services organizations.
5. "Primary care" means initial treatment or screening of enrollees.
6. "Primary care physician" means general practitioner, family physician, internist or pediatrician.
7. "Shall" and "must" means requirements.

Historical Note
Adopted effective August 25, 1975 (Supp. 75-1).

R9-12-104. Documentation

Where these regulations require a HCSO to have policies, procedures, plans, class specifications, orders, reports, minutes of meetings, contracts, agreements, records, duty schedules, or other similar items, such requirement means written documents compiled and indexed in one or more manuals which shall be readily available for inspection by the Director or his representatives.

Historical Note
Adopted effective August 25, 1975 (Supp. 75-1).

R9-12-105. Service agreements

Primary care physician services provided on a continuing basis by other than HCSO employees shall be covered by written service agreements which specify the terms and conditions upon which they will provide any or all of those health care services contained in R9-12-111(F).

Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

R9-12-106. Examination and review

Facilities of the HCSO and any primary care physician(s) with whom it contracts for services on a continuing basis shall be subject to inspection by personnel of the Department or other officials by delegation or other authority, pursuant to A.R.S. § 20-1058(D) and A.R.S. § 20-1064.

Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

R9-12-107. Reserved

R9-12-108. Reserved

R9-12-109. Reserved

R9-12-110. Reserved

R9-12-111. Health care plan

A. The applicant shall submit a statement which describes the proposed health care plan or plans, facilities, and personnel.

B. The HCSO shall have an organized system for the delivery of those health care services contained in subsection (F) of this Section which includes physicians, registered nurses and other professional and technical personnel. The system shall include a procedure which promotes a continuing relationship to be established between an enrollee and the same primary care physician and a procedure for effective referrals to assure continuity of care to enrollees.

C. The HCSO shall list (using full-time equivalents for providers) the proposed or actual:

1. Enrollment,
2. Physician staffing for said enrollment, identifying board eligibility or certification of each physician listed when applicable.
3. Medical support staff, and
4. Provision for providing specialty medical services.

D. All care provided by the HCSO whether provided by its own personnel or on a contract basis shall be by licensed:

1. Practitioners of the healing arts:
2. Health care institutions: or
3. Clinical laboratories

when any such licensure is required by law and shall otherwise be in accordance with applicable laws and regulations.

E. The health care services described in subsection (F), paragraphs (1), (2), (3), and (6) of this regulation shall be provided on a seven day per week and 24 hour per day basis.

F. The health care plan shall provide within the geographic area served at least the following basic health care services which shall be covered by the monthly charges set forth in the evidence of coverage:

1. Emergency care. Emergency care shall include those services rendered under unforeseen conditions which require hospitalization or services necessary for the repair of accidental injury, relief of acute pain, initial treatment of acute infection, and the amelioration of illness or conditions which, if not immediately diagnosed and treated, would result in extended or permanent physical impairment or loss of life.
2. Inpatient general hospital care.
3. Physician care. Physician care shall include necessary diagnostic and therapeutic services provided by a person who has a current and valid Arizona license to practice medicine and surgery.
4. Outpatient care. Outpatient care shall include preventive, diagnostic and therapeutic services, including primary care, furnished by or under the direction of a physician, and laboratory and radiology services. Primary care may include services provided by a physician's assistant (a person who has a current and valid registration under the applicable provisions of A.R.S. Title 32, Chapter 13, 17 and 25, to provide patient services as specified in his job description or approved program) or by a nurse practitioner in the extended role (a registered nurse certified by the Arizona State Board of Nursing to function in specialty areas, in accordance with the provisions of A.R.S. § 32-1601(B)(6), in collaboration with and under the direction of a physician).
5. Health maintenance care. Health maintenance care consists of care designed to prevent illness and to improve the general health of enrollees. It shall be offered when medically necessary or indicated and shall include:
   a. Immunizations
   b. Health education
   c. Periodic health examinations (excluding certified health examinations for insurance qualification, school attendance, and employment) which include screening for vision and hearing shall be offered when medically necessary or indicated and at least on the following schedule:
      i. Enrollees aged 0 - 1 year -- 1 exam every 4 months
         2 - 5 years -- 1 exam every year
         6 - 40 years -- 1 exam every 5 years
         41 - 50 years -- 1 exam every 3 years
         51 - 60 years -- 1 exam every 2 years
         61 years and over -- 1 exam every year
      ii. A medical history and health examination shall be offered to each new enrollee within 12 months after enrollment.
6. Ambulance services. Emergency ambulance services and other ambulance services when approved by a plan physician.

G. The HCSO shall provide appropriate coverage for out-of-area emergency care to enrollees when traveling outside the area served by the HCSO.

Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

R9-12-112. Geographic area

A. The applicant shall submit a statement which describes the geographic area or areas to be served. The applicant shall designate a geographic area or areas in which it will have the capability of providing services that are reasonably convenient to prospective enrollees.

1. The applicant shall attach a map or maps to the statement on which are indicated the boundaries of the proposed geographic area or areas and the locations of all facilities in which primary care will be provided under the plan.
2. The applicant shall describe the proposed geographic area or areas in at least one of the following ways:
   a. Legal description
   b. Local governmental jurisdiction such as city or county
   c. Census tracts
   d. Street boundaries

e. Area within a specified radius of a specified intersection or a specified primary care center.

B. All advertising matter and sales material provided to prospective enrollees must include a description of the geographic area or areas in terms readily understandable by the general public.

Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

R9-12-113. Chief executive officer

A. The governing authority shall appoint a chief executive officer who shall have appropriate education and experience to qualify him for the management of the HCSO. The governing authority shall define the authority and duties of the chief executive officer in writing. The chief executive officer shall be the appointed representative of the governing authority and shall be the executive officer of the HCSO. He shall be responsible for the implementation of established policies in the operation of the HCSO and for providing liaison between governing authority, providers of health care and providers of other services for the HCSO. He shall be in charge of the management of the HCSO and shall be authorized and empowered to carry out the provisions of this Article and shall be charged with the responsibility of doing so. The chief executive officer shall establish in writing a plan indicating the line of authority during periods of his absence.

B. When there is a change of chief executive officer, the governing authority shall notify the Department of Health Services and Department of Insurance within ten days after the effective date of change.

C. The HCSO shall assure that all HCSO employees and health practitioners covered by service agreements are adequately knowledgeable and qualified to perform the duties assigned to them through employment or by contract.

D. The HCSO shall designate a central place of business within the major geographic area served from which the administrative activities of the plan shall be directed and at which the chief executive officer shall be based.

Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

R9-12-114. Medical director

A. The HCSO shall designate a physician as medical director.

B. The medical director shall be responsible for planning and implementing the method for the continuing review and evaluation of health care provided by the HCSO and the continuing education of its providers of health care services. The medical director may also serve as the chief executive officer provided he has appropriate education and experience to qualify him for the management of the HCSO.

C. The medical director's responsibility shall include, but not be limited to:

1. Supervision including performance planning and evaluation of medical staff.
2. Coordination of activities of medical staff.
3. Development of medical care policies.

Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

R9-12-115. Medical records

A. The HCSO shall maintain a medical record system which is capable of readily providing necessary information and which assures continuity of enrollee care.

B. A centralized medical record shall be maintained in accordance with acceptable professional standards which includes records covering all symptoms presented, diagnoses made and medical treatment provided to each enrollee by the HCSO during the term of his enrollment. This requirement applies to all HCSO services provided to enrollees whether provided by employees of the HCSO or non-employees at the request of the HCSO.

C. There shall be a person designated as having the administrative responsibility for medical records.

D. Medical records shall be kept confidential. Only authorized personnel shall have access to the records.

E. Medical records shall be the property of the HCSO and shall not be removed from the premises wherein they are filed except by subpoena or court order. This does not preclude the routing of the record or portion thereof, including X-ray film, to practitioners of the healing arts for consultation or evaluation.

F. Pursuant to A.R.S. § 20-1058(D) and A.R.S. § 20-1064, the centralized medical records of the HCSO shall be made available for review by representatives of the Department. During routine surveys, the Department representatives will review medical records of the HCSO on a random sample basis. On complaint or special investigations, specific medical records will be reviewed. Title 9, Chapter 1, Article 3 of the Department rules and regulations prohibit employees of the Department from divulging patient names or other information from medical records unless specifically authorized by that Section.

G. Records shall be preserved in the original or by microfilm for a period of not less than ten (10) years. In the case of a minor, the record must be maintained for at least two years after the person has reached his majority.

H. If the enrollee discontinues enrollment in the HCSO, it shall furnish, upon his request, a written summary covering all pertinent phases of health care provided during enrollment including copies of pertinent reports and results of diagnostic tests which might be used for comparative purposes, a record of immunizations and the last periodic health examination to another provider of health care services as specified by the enrollee. If requested, this summary shall be furnished within 30 days after the enrollee requests disenrollment. A reasonable charge may be made for the summary based upon the cost of providing it.

Historical Note

Adopted effective August 25, 1975 (Supp. 75-1).

R9-12-116. Quality assurance

A. The HCSO shall provide an effective method for a continuing review and evaluation of the health care provided to ensure that treatment and level of care were appropriate and adequate, that the quality of health care provided met acceptable standards, and that corrective action occurred or will occur if indicated.

B. There shall be a quality assurance committee consisting of the chief executive officer or his designee, the medical director, practitioners of the healing arts, and allied health professionals. Services performed by practitioners of the healing arts shall be reviewed and evaluated by colleagues within their disciplines. The committee shall adopt administrative procedures covering frequency of meetings, types of records to be kept, and arrangements for committee reports and their dissemination.

C. There shall be a quality assurance plan which shall include procedures to be used for each of the following:

1. Establishment of standards for health care.
2. Surveillance of care provided.
3. Analysis of problems identified.

4. Correction of deficiencies including a time schedule for correction and a link to a continuing education program.
5. Follow-up (periodic reassessment of the plan).

Historical Note
Adopted effective August 25, 1975 (Supp. 75-1).

TITLE 9. HEALTH SERVICES

CHAPTER 13. DEPARTMENT OF HEALTH SERVICES HEALTH PROGRAMS SERVICES

ARTICLE 1. HEARING EVALUATION SERVICES

Article 1 consisting of Sections R9-13-101 through R9-13-110 adopted effective February 18, 1986.

Former Article 1 consisting of Sections R9-13-111 through R9-13-117 repealed effective February 18, 1986 (Supp. 86-1).

Section
R9-13-101. Definitions
R9-13-102. Population to be Screened
R9-13-103. Hearing Test Requirements
R9-13-104. Criteria for Pass/fail
R9-13-105. Referral Criteria and Notifications
R9-13-106. Follow-up Requirements
R9-13-107. Personnel Requirements for Screening
R9-13-108. Equipment Standards
R9-13-109. Reporting Requirements
R9-13-110. Repealed
R9-13-111. Repealed
R9-13-112. Renumbered
R9-13-113. Renumbered
R9-13-114. Repealed
R9-13-115. Repealed
R9-13-116. Renumbered
R9-13-117. Renumbered

ARTICLE 2. REPEALED

ARTICLE 3. REPEALED

Article 3 consisting of Sections R9-13-301 through R9-13-304 adopted effective July 16, 1981.

Article 3 consisting of Sections R9-13-301 through R9-13-306 repealed effective July 16, 1981.

ARTICLE 4. REPEALED

Article 4 consisting of Sections R9-13-401 through R9-13-406 repealed effective December 16, 1996 (Supp. 96-4).

Article 4 consisting of Sections R9-13-401 through R9-13-406 adopted effective July 16, 1981.

Article 4 consisting of Sections R9-13-401 through R9-13-407 repealed effective July 16, 1981.

ARTICLE 5. REPEALED

Article 5 consisting of Sections R9-13-501 through R9-13-504 adopted effective July 16, 1981.

Article 5 consisting of Sections R9-13-501 through R9-13-511 repealed effective July 16, 1981.

ARTICLE 6. REPEALED

Article 6 consisting of Sections R9-13-601 through R9-13-606 repealed effective December 16, 1996 (Supp. 96-4).

Article 6 consisting of Sections R9-13-601 through R9-13-606 adopted effective July 16, 1981.

Article 6 consisting of Sections R9-13-601 through R9-13-605 repealed effective July 16, 1981.

ARTICLE 7. REPEALED

Article 7 consisting of Sections R9-13-701 through R9-13-704 adopted effective July 16, 1981.

ARTICLE 8. BASIC EMERGENCY MEDICAL TECHNICAL CERTIFICATION

Article 8 consisting of Sections R9-13-801 through R9-13-806 adopted effective July 16, 1981.

Section
R9-13-801. Scope
R9-13-802. Authorized Treatment Activities
R9-13-803. Repealed
R9-13-804. Repealed
R9-13-805. Repealed
R9-13-806. Suspension and Revocation

ARTICLE 9. AMBULANCE ATTENDANT CERTIFICATION

Article 9 consisting of Section R9-13-901 adopted effective October 13, 1982.

Section
R9-13-901. Certification of ambulance attendants
R9-13-902. Emergency expired

ARTICLE 10. AMBULANCE SERVICE LICENSURE

Section
R9-13-1001. License application procedures
R9-13-1002. Surface, air and water ambulance service general responsibilities
R9-13-1003. Air ambulance service general responsibilities
R9-13-1004. Water ambulance service general responsibilities

ARTICLE 11. AMBULANCE REGISTRATION CERTIFICATE

Section
R9-13-1101. Registration certificate application procedures
R9-13-1102. Ambulance design requirements
R9-13-1103. Surface ambulance design requirements
R9-13-1104. Air ambulance design requirements
R9-13-1105. Water ambulance design requirements

ARTICLE 12. MISCELLANEOUS

Section
R9-13-1201. Waiver
R9-13-1202. Emergency expired

ARTICLE 13. ALS BASE HOSPITAL/IEMT CERTIFICATION

Article 13 consisting of Sections R9-13-1301 through R9-13-1303 adopted effective November 23, 1983.

Section
R9-13-1301. Supporting service agreements
R9-13-1302. Responsibilities and requirements
R9-13-1303. Suspension and revocation

ARTICLE 14. REGULATION OF AMBULANCES AND AMBULANCE SERVICES

Article 14 consisting of Sections R9-13-1401 through R9-13-1415 adopted effective March 19, 1984.

Article 14 consisting of Sections R9-13-1401 through R9-13-1417 adopted as an emergency effective November 29, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days.

Section
R9-13-1401. Definitions
R9-13-1402. Application for Certificate of Necessity
R9-13-1403. Hearings; general provisions
R9-13-1404. Certificate of Necessity; term; posting; general provisions
R9-13-1405. Transfer of ambulance service
R9-13-1406. Suspension and revocation
R9-13-1407. Abandonment or discontinuance of service
R9-13-1408. Rates and charges; exemption; rate increase; filing and posting of schedule
R9-13-1409. Insurance or financial responsibility
R9-13-1410. Required records; reports and data; inspection
R9-13-1411. Recordkeeping methods and accounts
R9-13-1412. Fees for copying; fees not refundable
R9-13-1413. Inspections
R9-13-1414. Reports
R9-13-1415. Miscellaneous
R9-13-1416. Emergency expired
R9-13-1417. Emergency expired

ARTICLE 15. RECODIFIED

Editor's Note: Article 15, consisting of R9-13-1501 through R9-3-1503 and Exhibits, was recodified to 9 A.A.C. 25.

Editor's Note: Former Article 15 was originally adopted, and subsequently amended by the addition of a new Section, under an exemption from the provisions of the Administrative Procedure Act which means that the rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify the rules.

Article 15, consisting of Sections R9-13-1501 through R9-13-1503, recodified to 9 A.A.C. 25, R9-25-801 through R9-25-803 (Supp. 98-1).

ARTICLE 1. HEARING EVALUATION SERVICES

R9-13-101. Definitions

In this Article, unless the context otherwise requires:

1. "ANSI" means the American National Standards Institute which approves the equipment standards for audiometers.
2. "At risk" means the presence of conditions or symptoms which indicate a possibility of developing hearing problems.
3. "Audiologist" means a professional who specializes in the identification and prevention of hearing problems and in the nonmedical rehabilitation of those who have hearing problems. An audiologist holds a Master's or Doctoral degree in audiology and holds an Certificate of Clinical Competence in Audiology from the American Speech- Language-Hearing Association.
4. "Audiometer" means an electronic device that generates signals used to measure hearing thresholds.
5. "Calibration" means an electronic check to determine the precise characteristics of audiometric equipment.
6. "Compliance" means the ease with which the eardrum and middle ear mechanism moves.
7. "Certificate of Clinical Competence" means the professional standard of practice for individuals who provide independent clinical services in either audiology or speech-language pathology as set forth in the American Speech-Language-Hearing Association (ASHA) publication, March 1989, Standards for the Certificate of Clinical Competence, c/o American Speech-Language-Hearing Association, 10801 Rockville Pike, Rockville, Maryland 20852-3279, incorporated herein by reference and on file with the Office of the Secretary of State.
8. "Frequency" means the number of cycles per second of a sound wave.
9. "HCP" means the Hearing Conservation Program, Division of Family Health Services, Department of Health Services.
10. "Hz" means Hertz, a unit of frequency equal to one cycle per second.
11. "Hearing screening" means the evaluation of the ability to hear certain frequencies at a consistent loudness and may include an evaluation of the function of the middle ear system.
12. "Intensity" means the amount of acoustic energy which gives the sensation of loudness. Intensity is expressed in decibels (dB) or decibels hearing level (dB HL).
13. "Local Education Agency" means a public school district as defined in A.R.S. § 15-101.
14. "Noise letter" means a letter containing information regarding the adverse effects of exposure to loud noise and a recommendation for audiological or medical examination.
15. "Speech-language pathologist" means a professional who specializes in the assessment, prevention, and nonmedical treatment of communication disorders; holds a Master's or Doctoral degree in speech-language pathology; and holds a Certificate of Clinical Competence in speech-language pathology from the American Speech-Language-Hearing Association.
16. "Threshold" means the lowest intensity level at which a pure tone is detectable during 50% of the presentations.
17. "Tympanogram" means a chart of the results of compliance measurements of the eardrum and middle ear system as a function of pressure. Information on a tympanogram shall include pressure, compliance, and physical volume.
18. "Tympanometry" means the measurement of changes in the compliance of the middle ear system as air pressure is varied in the external ear canal.

Historical Note

Adopted effective February 18, 1986 (Supp. 86-1).
Amended effective October 15, 1993 (Supp. 93-4).

R9-13-102. Population to be Screened

Unless the parent or legal guardian objects and submits a statement of such objection, a public or private school shall administer a hearing screening, in accordance with R9-13-103, to each child who comes within one of the following categories during the school year:

1. Children in preschool handicapped programs, kindergarten, and grades 1, 2, 6, and 9 or 10;
2. Children who repeated a grade within the past academic year;
3. Children who currently are receiving special education services and/or related services;
4. Children who enter school without record of a hearing test having been administered within one year prior to entry;
5. Children who failed a hearing rescreening within the previous year;
6. Children who have a documented hearing loss;
7. Children who are referred by a parent; guardian; teacher; administrator; school nurse; other school professional,

including a speech pathologist, a school psychologist, or a staff member of the HCP; or self-referred for screening;
8. Students who have participated in industrial arts shop classes for more than one quarter; or
9. Children identified as "at risk" for hearing problems during the previous year's hearing screening.

Historical Note
Former Section R9-13-112 renumbered and amended as Section R9-13-102 effective February 18, 1986 (Supp. 86-1). Amended effective October 15, 1993 (Supp. 93-4).

R9-13-103. Hearing Test Requirements

A. Children to be tested shall be given one of the following initial screening tests:
1. A four-frequency, pure-tone screening test. The following frequencies and their intensity in dB HL shall be utilized for the initial pure tone screening: 500 Hz at 25 dB HL, 1000 Hz at 20 dB HL, 2000 Hz at 20 dB HL, and 4000 Hz at 20 dB HL.
2. A tympanometry screening in conjunction with a three-frequency, pure-tone screening.
   a. The tympanogram shall be plotted at three points: +200 mm H20, point of maximum compliance, and -300 mm H20.
   b. The three-frequency screening shall occur at 1000 Hz, 2000 Hz, and 4000 Hz at 20 dB HL.

B. Children who fail either of the initial screening procedures shall be retested within 4 - 6 weeks.

C. Children who fail the second screening shall be given a threshold test within two weeks of the second screening utilizing the following frequencies: 500 Hz, 1000 Hz, 2000 Hz, 3000 Hz, 4000 Hz, and 8000 Hz.

Historical Note
Adopted effective February 18, 1986 (Supp. 86-1). Amended effective October 15, 1993 (Supp. 93-4).

R9-13-104. Criteria for Pass/fail

A. A child shall fail the initial four-frequency pure-tone screening if there is not a response to each frequency at the prescribed screening level in each ear.

B. A child shall fail the tympanometry and three-frequency initial screening if any of the following conditions exist:
1. Peak compliance occurs outside the range of +100 mm H20 to -200 mm H20,
2. No point of maximum compliance occurs between +100 and -300 mm H20 (Type B tympanogram), or
3. No response occurs to the pure-tone screen at 1000 Hz, 2000 Hz, or 4000 Hz in either ear.

Historical Note
Adopted effective February 18, 1986 (Supp. 86-1). Amended effective October 15, 1993 (Supp. 93-4).

R9-13-105. Referral Criteria and Notifications

A. The school shall provide a medical referral notification to the child's parent or legal guardian when any of the following conditions are determined to exist:
1. A hearing threshold level in one or more of the following frequencies which equals or exceeds 30 dB at 500 Hz, or 25 dB at 1000 Hz, 2000 Hz, 3000 Hz, 4000 Hz, and 8000 Hz in either ear;
2. Tympanometry indicates that peak compliance occurs outside the range of +100 to -200 mm H20; or
3. Tympanometry indicates that the point of maximum compliance does not occur between +100 and -300 mm H20.

B. The school shall provide a referral notification for an audiological evaluation to the child's parent or legal guardian when any of the following conditions exist:
1. The tympanometry portion of the screening is passed while the pure-tone portion of the screening is failed;
2. A child with a confirmed hearing loss responds to pure-tone threshold testing at a level of more than 10 dB poorer, at any frequency, than that indicated by threshold test results of the previous year; or
3. A child is wearing a hearing aid, in which case an annual audiological referral shall be made that includes a recommendation for an electroacoustic analysis of the aid to verify that it is functioning according to manufacturer's specifications.

C. The school shall notify the child's parent or legal guardian if the hearing test results indicate the need for medical or audiological referral. The referral notification shall be by letter or documented telephone call within ten working days of the test. A copy of the hearing test results and the otologic report form, to be completed by the child's physician, also shall be sent to the parent or legal guardian.

D. The school shall send a noise letter to the child's parent or legal guardian if the child's greatest degree of loss occurs at 4000 Hz in either ear.

E. Subsequent to tympanometry rescreening and threshold testing, the school shall consider a child "at risk" for hearing problems if peak compliance occurs from -160 mm through -200 mm H20 and the child's hearing threshold levels are within screening limits. The "at risk" determination shall require the school to send a letter to the child's parent or legal guardian containing suggestions for identification of behaviors which indicate possible middle ear disorder.

Historical Note
Adopted effective February 18, 1986 (Supp. 86-1). Amended effective October 15, 1993 (Supp. 93-4).

R9-13-106. Follow-up Requirements

A. The school shall request that a child's parent or legal guardian return the otologic report form to the school subsequent to the child's medical examination.

B. The school nurse or other person responsible for the school hearing program shall inform the classroom teachers of the presence of students who have documented hearing loss.

C. The parent, legal guardian, school nurse, audiologist, physician, or other consultants, including a speech pathologist, a school psychologist, or a staff member of the HCP may request that a child with documented hearing loss be referred for evaluation for special education placement and services in accordance with the State Board of Education rule A.A.C. R7-2-401 (Special Education Standards for Public Schools and State-supported Institutions).

D. The local education agency shall be responsible for audiological evaluations for students enrolled in special education services or under evaluation for special education services in accordance with the State Board of Education rule A.A.C. R7-2-401 (Special Education Standards for Public Schools and State-supported Institutions).

Historical Note
Adopted effective February 18, 1986 (Supp. 86-1). Amended effective October 15, 1993 (Supp. 93-4).

R9-13-107. Personnel Requirements for Screening

A. Aides may perform initial pure-tone screening under the direct supervision of an audiologist, speech-language pathologist, or an individual who has completed an HCP certification course.

B. Threshold testing and tympanometry shall be performed only by an audiologist, speech-language pathologist, or an individual who has completed an HCP certification course.

Historical Note
Former Section R9-13-113 renumbered and amended as Section R9-13-107 effective February 18, 1986 (Supp. 86-1). Amended effective October 15, 1993 (Supp. 93-4).

R9-13-108. Equipment Standards

A. For pure-tone testing, the pure-tone audiometer and the pure-tone component of an acoustic impedance meter shall be calibrated to ANSI standards which are set forth in The American National Standard Specification for Audiometers, ANSI S3.6-1989, Standards Secretariat, c/o Acoustical Society of America, 335 East 45th Street, New York, New York 10017-3483, incorporated herein by reference and on file with the Office of the Secretary of State.

B. If tympanometry is included in the testing protocol, the acoustic impedance meter shall be equipped with either a calibration test cavity or programmed to self-calibrate. The acoustic impedance meter shall be calibrated on a daily basis, shall have an air pressure range of +200 mm to -300 mm H20, and shall utilize a low frequency probe tone of 220 to 300 Hz.

C. Each audiometer or acoustic impedance meter shall have a complete calibration check annually as follows:

1. The check for audiometers shall meet the ANSI standards set forth in subsection (A).
2. The check for acoustic impedance meters shall be performed according to manufacturer's specifications. If there is an audiometer component to the acoustic impedance meter, that component shall be tested in accordance with the requirements of subsection (A) for pure-tone audiometers.
3. Listening checks of the audiometers shall be made each day they are used and each time they are moved to a different location. The listening checks shall assure the following:
   a. Power source and power indicator lights are working,
   b. Earphone cords are free of breaks and loose connections,
   c. All test frequencies are present at screening levels as specified in R9-13-103(A)(1),
   d. Earphones are free of crossover of the signal to the opposite earphone, and
   e. Earphones are free of any extraneous noise or distortion that may interfere with the screening.
4. Acoustic impedance meters shall comply with the following:
   a. Test cavity calibration checks shall be performed daily per manufacturer's specifications before initial testing and each time that the unit is moved.
   b. Routine inspections for obstruction in the probe unit shall be performed prior to testing each child.
   c. If the acoustic impedance meter contains a pure-tone component, a listening check shall be performed as outlined in paragraph (3).

D. If equipment is not found to meet minimum standards outlined above, it shall not be used for testing.

Historical Note
Adopted effective February 18, 1986 (Supp. 86-1). Amended effective October 15, 1993 (Supp. 93-4).

R9-13-109. Reporting Requirements

A. The result of each child's hearing test shall be recorded on the school or health record together with the date of the test and the child's grade, or age equivalent.

B. By June 30th of each year, each school shall submit a written report of the school year's HCP results to the Director utilizing forms prescribed by the Department. The report shall include the number of students classified into the following categories:

1. Screened initially;
2. Failed the first screening;
3. Received the second screening;
4. Failed the second screening and were given:
   a. Threshold test,
   b. Medical referrals,
   c. Medical examinations,
   d. Audiological referrals,
   e. Audiological examinations,
   f. Hearing aid evaluations, and
   g. Special education evaluations; and
5. Wore hearing aids.

C. By June 30th of each year, each school shall report the name of the person responsible for administering the hearing screening program to the Director along with a copy of that person's HCP training course certificate or Certificate of Clinical Competence in audiology or speech-language pathology.

Historical Note
Former Section R9-13-116 renumbered and amended as Section R9-13-109 effective February 18, 1986 (Supp. 86-1). Amended effective October 15, 1993 (Supp. 93-4).

R9-13-110. Repealed

Historical Note
Former Section R9-13-117 renumbered and amended as Section R9-13-110 effective February 18, 1986 (Supp. 86-1). Repealed effective October 15, 1993 (Supp. 93-4).

R9-13-111. Repealed

Historical Note
Effective 4-72. Amended effective November 18, 1976 (Supp. 76-5). Repealed effective February 18, 1986 (Supp. 86-1).

R9-13-112. Renumbered

Historical Note
Effective 4-72. Amended effective November 18, 1976 (Supp. 76-5). Section R9-13-112 renumbered and amended as Section R9-13-102 effective February 18, 1986 (Supp. 86-1).

R9-13-113. Renumbered

Historical Note
Effective 4-72. Amended effective November 18, 1976 (Supp. 76-5). Section R9-13-113 renumbered and amended as Section R9-13-107 effective February 18, 1986 (Supp. 86-1).

R9-13-114. Repealed

Historical Note
Effective 4-72. Amended effective November 18, 1976 (Supp. 76-5). Repealed effective February 18, 1986 (Supp. 86-1).

R9-13-115. Repealed

Historical Note
Effective 4-72. Amended effective November 18, 1976 (Supp. 76-5). Repealed effective February 18, 1986 (Supp. 86-1).

R9-13-116. Renumbered

Historical Note
Effective 4-72. Correction, Section R9-13-116 omitted in Supp. 76-5 (Supp. 77-5). Section R9-13-116 renumbered and amended as Section R9-13-109 effective February 18, 1986 (Supp. 86-1).

R9-13-117. Renumbered

Historical Note
Effective 4-72. Correction, Section R9-13-117 omitted in Supp. 76-5 (Supp. 77-5). Section R9-13-117 renumbered and amended as Section R9-13-110 effective February 18, 1986 (Supp. 86-1).

ARTICLE 2. REPEALED

R9-13-201. Repealed

Historical Note
Amended effective October 26, 1977 (Supp. 77-5). Former Section R9-13-201 repealed, new Section R9-13-201 adopted effective July 16, 1981 (Supp. 81-4). Amended as an emergency effective September 21, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-5). Emergency expired. Permanent rule adopted effective March 22, 1983 (Supp. 83-2). Amended by adding paragraphs (3), (5) and (7) and renumbering remaining paragraphs effective November 23, 1983. Amended as an emergency, by adding paragraphs (32) and (42) and renumbering remaining paragraphs, effective November 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency amendment expired. Permanent amendment, adding paragraphs (32) and (42) and renumbering remaining paragraphs adopted effective March 19, 1984 (Supp. 84-2). Amended as an emergency effective November 6, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency expired. Readopted as an emergency effective February 7, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-1). Re-adopted as an emergency with changes effective May 7, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Readopted as an emergency with changes effective August 6, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Readopted as an emergency without change effective October 31, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-4). Readopted as an emergency with changes effective January 16, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-1). Readopted as an emergency without change effective April 11, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency amendments permanently adopted with changes effective July 3, 1991 (Supp. 91-3). Amended effective December 16, 1996 (Supp. 96-4). Section automatically repealed by final rulemaking at 3 A.A.R. 146, effective September 24, 1998 (Supp. 99-1).

R9-13-202. Repealed

Historical Note
Amended effective October 26, 1977 (Supp. 77-5). Former Section R9-13-202 repealed, new Section R9-13-202 adopted effective July 16, 1981 (Supp. 81-4). Repealed by emergency effective November 6, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency expired. Emergency repeal readopted effective February 7, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-1). Emergency repeal readopted effective May 7, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency repeal readopted effective August 6, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Emergency repeal readopted effective October 31, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-4). Emergency repeal readopted effective January 16, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-1). Emergency repeal readopted effective April 11, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Repealed permanently effective July 3, 1991 (Supp. 91-3).

R9-13-203. Repealed

Historical Note
Effective 11-74; Former Section R9-13-203 repealed, new Section R9-13-203 adopted effective July 16, 1981 (Supp. 81-4). Amended effective December 16, 1996 (Supp. 96-4). Section automatically repealed by final rulemaking at 3 A.A.R. 146, effective September 24, 1998 (Supp. 99-1).

R9-13-204. Repealed

Historical Note
Effective 11-74; Former Section R9-13-204 repealed, new Section R9-13-204 adopted effective July 16, 1981 (Supp. 81-4). Amended effective December 6, 1996 (Supp. 96-4). Section automatically repealed by final rulemaking at 3 A.A.R. 146, effective September 24, 1998 (Supp. 99-1).

R9-13-205. Repealed

Historical Note
Effective 11-74; Former Section R9-13-205 repealed, new Section R9-13-205 adopted effective July 16, 1981 (Supp. 81-4). Amended effective December 6, 1996 (Supp. 96-4). Section automatically repealed by final rulemaking at 3 A.A.R. 146, effective September 24, 1998 (Supp. 99-1).

R9-13-206. Repealed

Historical Note
Effective 11-74; Repealed effective July 16, 1981 (Supp. 81-4). Adopted as an emergency effective November 6, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency expired. Readopted as an emergency effective February 7, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-1). Emergency expired. Readopted as an emergency with changes effective May 7, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Readopted as an emergency with changes effective August 6, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-3). Readopted as an emergency without change

effective October 31, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-4). Readopted as an emergency without change effective January 16, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-1). Readopted as an emergency without change effective April 11, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency rule permanently adopted with changes effective July 3, 1991 (Supp. 91-3). Amended effective December 16, 1996 (Supp. 96-4). Section automatically repealed by final rulemaking at 3 A.A.R. 146, effective September 24, 1998 (Supp. 99-1).

R9-13-207. Repealed

Historical Note
Effective 11-74; Repealed effective July 16, 1981 (Supp. 81-4).

ARTICLE 3. REPEALED

R9-13-301. Repealed

Historical Note
Effective 11-74; Former Section R9-13-301 repealed, new Section R9-13-301 adopted effective July 16, 1981 (Supp. 81-4). Amended effective December 16, 1996 (Supp. 96-4). Section automatically repealed by final rulemaking at 3 A.A.R. 146, effective September 10, 1997 (Supp. 99-1).

R9-13-302. Repealed

Historical Note
Effective 11-74; Former Section R9-13-302 repealed, new Section R9-13-302 adopted effective July 16, 1981 (Supp. 81-4). Amended effective December 16, 1996 (Supp. 96-4). Section automatically repealed by final rulemaking at 3 A.A.R. 146, effective September 10, 1997 (Supp. 99-1).

R9-13-303. Repealed

Historical Note
Effective 11-74; Former Section R9-13-303 repealed, new Section R9-13-303 adopted effective July 16, 1981 (Supp. 81-4). Repealed effective December 16, 1996 (Supp. 96-4).

R9-13-304. Repealed

Historical Note
Effective 11-74; Former Section R9-13-304 repealed, new Section R9-13-304 adopted effective July 16, 1981 (Supp. 81-4). Amended effective December 16, 1996 (Supp. 96-4). Section automatically repealed by final rulemaking at 3 A.A.R. 146, effective September 10, 1997 (Supp. 99-1).

R9-13-305. Repealed

Historical Note
Effective 11-74; Repealed effective July 16, 1981 (Supp. 81-4).

R9-13-306. Repealed

Historical Note
Effective 11-74; Repealed effective July 16, 1981 (Supp. 81-4).

ARTICLE 4. REPEALED

R9-13-401. Repealed

Historical Note
Effective 11-74; Former Section R9-13-401 repealed, new Section R9-13-401 adopted effective July 16, 1981 (Supp. 81-4). Repealed effective December 16, 1996 (Supp. 96-4).

R9-13-402. Repealed

Historical Note
Effective 11-74; Former Section R9-13-402 repealed, new Section R9-13-402 adopted effective July 16, 1981 (Supp. 81-4). Repealed effective December 16, 1996 (Supp. 96-4).

R9-13-403. Repealed

Historical Note
Effective 11-74; Former Section R9-13-403 repealed, new Section R9-13-403 adopted effective July 16, 1981 (Supp. 81-4). Repealed effective December 16, 1996 (Supp. 96-4).

R9-13-404. Repealed

Historical Note
Effective 11-74; Former Section R9-13-404 repealed, new Section R9-13-404 adopted effective July 16, 1981 (Supp. 81-4). Repealed effective December 16, 1996 (Supp. 96-4).

R9-13-405. Repealed

Historical Note
Effective 11-74; Former Section R9-13-405 repealed, new Section R9-13-405 adopted effective July 16, 1981 (Supp. 81-4). Repealed effective December 16, 1996 (Supp. 96-4).

R9-13-406. Repealed

Historical Note
Effective 11-74; Former Section R9-13-406 repealed, new Section R9-13-406 adopted effective July 16, 1981 (Supp. 81-4). Repealed effective December 16, 1996 (Supp. 96-4).

R9-13-407. Repealed

Historical Note
Effective 11-74; Repealed effective July 16, 1981 (Supp. 81-4).

ARTICLE 5. REPEALED

R9-13-501. Repealed

Historical Note
Adopted effective October 26, 1977 (Supp. 77-5). Former Section R9-13-501 repealed, new Section R9-13-501 adopted effective July 16, 1981 (Supp. 81-4). Amended effective December 16, 1996 (Supp. 96-4). Section automatically repealed by final rulemaking at 3 A.A.R. 146, effective March 23, 1997 (Supp. 99-1).

R9-13-502. Repealed

Historical Note
Adopted effective October 26, 1977 (Supp. 77-5). Former Section R9-13-502 repealed, new Section R9-13-502 adopted effective July 16, 1981 (Supp. 81-4). Amended effective December 16, 1996 (Supp. 96-4). Section

automatically repealed by final rulemaking at 3 A.A.R. 146, effective March 23, 1997 (Supp. 99-1).

R9-13-503. Repealed

Historical Note
Adopted effective October 26, 1977 (Supp. 77-5). Former Section R9-13-503 repealed, new Section R9-13-503 adopted effective July 16, 1981 (Supp. 81-4). Repealed effective December 16, 1996 (Supp. 96-4).

R9-13-504. Repealed

Historical Note
Adopted effective October 26, 1977 (Supp. 77-5). Former Section R9-13-504 repealed, new Section R9-13-504 adopted effective July 16, 1981 (Supp. 81-4). Amended effective December 16, 1996 (Supp. 96-4). Section automatically repealed by final rulemaking at 3 A.A.R. 146, effective March 23, 1997 (Supp. 99-1).

R9-13-505. Repealed

Historical Note
Adopted effective 1977 (Supp. 77-5). Repealed effective July 16, 1981 (Supp. 81-4).

R9-13-506. Repealed

Historical Note
Adopted effective 1977 (Supp. 77-5). Repealed effective July 16, 1981 (Supp. 81-4).

R9-13-507. Repealed

Historical Note
Adopted effective 1977 (Supp. 77-5). Repealed effective July 16, 1981 (Supp. 81-4).

R9-13-508. Repealed

Historical Note
Adopted effective 1977 (Supp. 77-5). Repealed effective July 16, 1981 (Supp. 81-4).

R9-13-509. Repealed

Historical Note
Adopted effective 1977 (Supp. 77-5). Repealed effective July 16, 1981 (Supp. 81-4).

R9-13-510. Repealed

Historical Note
Adopted effective 1977 (Supp. 77-5). Repealed effective July 16, 1981 (Supp. 81-4).

R9-13-511. Repealed

Historical Note
Adopted effective 1977 (Supp. 77-5). Repealed effective July 16, 1981 (Supp. 81-4).

ARTICLE 6. REPEALED

R9-13-601. Repealed

Historical Note
Adopted effective October 26, 1977 (Supp. 77-5). Former Section R9-13-601 repealed, new Section R9-13-601 adopted effective July 16, 1981 (Supp. 81-4). Repealed effective December 16, 1996 (Supp. 96-4).

R9-13-602. Repealed

Historical Note
Adopted effective October 26, 1977 (Supp. 77-5). Former Section R9-13-602 repealed, new Section R9-13-602 adopted effective July 16, 1981 (Supp. 81-4). Amended effective July 3, 1991 (Supp. 91-3). Repealed effective December 16, 1996 (Supp. 96-4).

R9-13-603. Repealed

Historical Note
Adopted effective October 26, 1977 (Supp. 77-5). Former Section R9-13-603 repealed, new Section R9-13-603 adopted effective July 16, 1981 (Supp. 81-4). Repealed effective December 16, 1996 (Supp. 96-4).

R9-13-604. Repealed

Historical Note
Adopted effective October 26, 1977 (Supp. 77-5). Former Section R9-13-604 repealed, new Section R9-13-604 adopted effective July 16, 1981 (Supp. 81-4). Repealed effective December 16, 1996 (Supp. 96-4).

R9-13-605. Repealed

Historical Note
Adopted effective October 26, 1977 (Supp. 77-5). Former Section R9-13-605 repealed, new Section R9-13-605 adopted effective July 16, 1981 (Supp. 81-4). Amended effective July 3, 1991 (Supp. 91-3). Repealed effective December 16, 1996 (Supp. 96-4).

R9-13-606. Repealed

Historical Note
Adopted effective July 16, 1981 (Supp. 81-4). Repealed effective December 16, 1996 (Supp. 96-4).

ARTICLE 7. REPEALED

R9-13-701. Repealed

Historical Note
Adopted effective July 16, 1981 (Supp. 81-4). Amended effective December 16, 1996 (Supp. 96-4). Section automatically repealed by final rulemaking at 3 A.A.R. 146, effective June 1, 1997 (Supp. 99-1).

R9-13-702. Repealed

Historical Note
Adopted effective July 16, 1981 (Supp. 81-4). Amended effective December 16, 1996 (Supp. 96-4). Section automatically repealed by final rulemaking at 3 A.A.R. 146, effective June 1, 1997 (Supp. 99-1).

R9-13-703. Repealed

Historical Note
Adopted effective July 16, 1981 (Supp. 81-4). Repealed effective December 16, 1996 (Supp. 96-4).

R9-13-704. Repealed

Historical Note
Adopted effective July 16, 1981 (Supp. 81-4). Amended effective December 16, 1996 (Supp. 96-4). Section automatically repealed by final rulemaking at 3 A.A.R. 146, effective June 1, 1997 (Supp. 99-1).

ARTICLE 8. BASIC EMERGENCY MEDICAL TECHNICIAN CERTIFICATION

R9-13-801. Scope

A. The rules in this Article provide for the certification of basic emergency medical technicians. Persons certified as basic emergency medical technicians are authorized to provide emergency medical care to the sick and injured as provided in A.R.S. § 36-2201 et seq. and this Article.

B. This Article applies only to basic emergency technicians for whom current certification began before the effective date of this Section.

C. This rule is repealed on June 1, 2000.

Historical Note

Adopted effective July 16, 1981 (Supp. 81-4). Amended effective December 16, 1996 (Supp. 96-4).

R9-13-802. Authorized Treatment Activities

A. Persons certified as basic emergency medical technicians (EMT's) shall be competent in the recognition, assessment, and management of emergency medical situations; performance of basic life support; extrication; coordination with agencies involved in patient care and transportation; documentation and communication of pertinent medical information; and maintenance and preparation of emergency care equipment and supplies.

B. For the purpose of carrying out the competencies described in subsection (A), the certified basic EMT is authorized to perform the following activities:

1. Recognize emergencies of the following general activities:
   a. Medical.
   b. Environmental.
   c. Obstetrical.
   d. Traumatic.
   e. Surgical.
2. Obtain and interpret diagnostic signs and symptoms.
3. Perform basic cardiac life support.
4. Control hemorrhage and bandage wounds.
5. Stabilize and splint fractures.
6. Administer oxygen.
7. Care for behavioral emergencies.
8. Assist in childbirth.
9. Extricate, lift, move, position, and otherwise handle patients to minimize discomfort and additional injury.
10. Apply Medical Anti-Shock Trousers (MAST).

C. A certified BEMT shall be authorized by the Department to use automatic/semiautomatic defibrillation under the following conditions:

1. Be employed by an emergency medical services provider which is offering such procedure and has a written and signed provider agreement with an ALS base hospital medical director to provide training and medical control for the BEMT;
2. Have a certificate of training and proficiency for automatic/semiautomatic defibrillation issued by the ALS base hospital medical director responsible for such training;
3. Only use the type of automatic/semiautomatic defibrillator on which the person has been trained; and
4. Pass a written examination administered by the Department with a passing score of 75%. Unless the BEMT passes the test within 1 year after successfully completing the training program required by subsection (C)(2), the BEMT shall repeat the training program.

D. This rule is repealed on June 1, 2000.

Historical Note

Adopted effective July 16, 1981 (Supp. 81-4). Amended by emergency effective November 6, 1989, pursuant to A.R.S. 41-1026, valid for only 90 days (Supp. 89-4). Emergency expired, Readopted as an emergency effective February 7, 1990, pursuant to A.R.S. 41-1026, valid for only 90 days (Supp. 90-1). Emergency expired. Readopted as an emergency with changes effective May 7, 1990, pursuant to A.R.S. 41-1026, valid for only 90 days (Supp. 90-2). Readopted as an emergency with changes effective August 6, 1990, pursuant to A.R.S. 41-1026, valid for only 90 days (Supp. 90-3). Readopted as an emergency without change effective October 31, 1990, pursuant to A.R.S. 41-1026, valid for only 90 days (Supp. 90-4). Readopted as an emergency without change effective January 16, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-1). Readopted as an emergency without change effective April 11, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency rule permanently adopted effective July 3, 1991 (Supp. 91-3). Amended effective December 16, 1996 (Supp. 96-4).

R9-13-803. Repealed

Historical Note

Adopted effective July 16, 1981 (Supp. 81-4). Repealed effective December 16, 1996 (Supp. 96-4).

R9-13-804. Repealed

Historical Note

Adopted effective July 16, 1981 (Supp. 81-4). Repealed effective December 16, 1996 (Supp. 96-4).

R9-13-805. Repealed

Historical Note

Adopted effective July 16, 1981 (Supp. 81-4). Amended effective July 3, 1991 (Supp. 91-3). Amended effective December 16, 1996 (Supp. 96-4). Section automatically repealed by final rulemaking at 3 A.A.R. 146, effective June 30, 1998 (Supp. 99-1).

R9-13-806. Suspension and Revocation

A. After notice and opportunity to be heard is given according to the procedures described in A.R.S. Title 41, Chapter 6, Article 1 and in 9 A.A.C. 1, Article 1, certification may be suspended or revoked upon the following grounds:

1. That the EMT has in any way falsified any document provided to the Department for the purpose of evaluation or certification.
2. That the EMT has failed to conform with the applicable requirements of A.R.S. Title 36, Chapter 21.1, Article 1 or the rules in this Article.
3. That the EMT is incompetent, has engaged in unprofessional conduct, or is physically or mentally unable to safely engage in the rendition of services. Examples of the foregoing include:
   a. Addiction to drugs including alcohol.
   b. Conviction of a felony.
   c. Professional discipline in another jurisdiction.

B. If, in the opinion of the Director, there is sufficient information indicating that the EMT has engaged in the activities described in subsection (A), the Director may request an informal interview with the EMT concerned. If the EMT refuses such invitation or if the results of such interview indicate suspension or revocation of certification might be in order, then a complaint may be issued and a formal hearing may be

held in compliance with A.R.S. Title 41, Chapter 6, Article 1 and 9 A.A.C. 1, Article 1.

C. This rule is repealed on June 1, 2000.

Historical Note

Adopted effective July 16, 1981 (Supp. 81-4). Amended effective December 16, 1996 (Supp. 96-4).

ARTICLE 9. AMBULANCE ATTENDANT CERTIFICATION

R9-13-901. Certification of ambulance attendants

A. A person who is a certified emergency medical technician as defined in A.R.S. § 36-2201 and is 18 years of age or older is deemed to be a certified ambulance attendant under A.R.S. § 36-2202. A person not so certified will not be certified as an ambulance attendant.

B. The term of a person's ambulance attendant certification is deemed concurrent with the person's emergency medical technician certification.

Historical Note

Adopted as an emergency effective April 6, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-2). Former Section R9-13-901 expired, new Section R9-13-901 adopted as a permanent rule effective October 13, 1982 (Supp. 82-5).

R9-13-902. Emergency expired

Historical Note

Adopted as an emergency effective April 6, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-2). Former Section R9-13-902 expired (Supp. 82-5).

ARTICLE 10. AMBULANCE SERVICE LICENSURE

R9-13-1001. License application procedures

A. The ambulance service license shall be valid on the date of issuance and must be renewed annually.

B. A person applying for surface, air and water ambulance service license shall:

1. Complete and submit an application using forms provided by the Division not less than 30 days prior to the requested effective date of the ambulance service license. The application shall contain the name and address of the applicant and owner of the ambulance service, a description of the ambulance to be registered, a roster of EMS personnel to be employed, location and description of the place or places from which the service intends to operate and such other information necessary to determine compliance with applicable statutes and these regulations.
2. Include proof of liability and malpractice insurance to a minimum of $1,000.000.
3. Submit a complete list of personnel to be utilized as ambulance attendants.
4. Make all equipment, including ambulances, available for inspection prior to issuance of an ambulance service license.
5. Assure that the premises on which ambulances are parked, housed, docked or hangared, and on which ambulance equipment or supplies are stored, are designated as such and made accessible for inspection prior to issuance of an ambulance license.
6. Submit a check or money order, payable to the Arizona Department of Health Services, in the amount of $100 at the time of application for ambulance service licensure.
7. Submit other information as requested by the Division to assure compliance with these regulations or applicable provisions of law.

C. License renewal application procedures. Any person applying for surface, air and water ambulance service license renewal shall:

1. Complete and submit an application for ambulance service license renewal not less than 30 days prior to the expiration date of the current license to assure continuity.
2. Apply for renewal using forms provided by the Division and indicate compliance with the requirements as set forth for original license, including inspections.
3. Submit a check or money order payable to the Arizona Department of Health Services, in the amount of $100 for renewal of ambulance service license at the time of application.

D. Termination of service

1. Prior to termination of ambulance service, the licensee shall give the Department 30 days notice. Termination of service shall void the ambulance service license.

E. Suspension and revocation

1. After notice and opportunity to be heard is given according to the procedures described in A.R.S. Title 41, Chapter 6, Article 1 and in Chapter 1, Article 1 of this Title, a license may be suspended or revoked upon the grounds set forth in A.R.S. § 36-2215(A).
2. If, in the opinion of the Director, there is sufficient information indicating that the licensee has engaged in the activities described in paragraph (1) of this subsection, the Director may request an informal interview with the licensee. If such invitation is refused, or if the interview is attended and the results indicate suspension or revocation of the license might be in order, then a complaint may be issued and a formal hearing may be held in compliance with A.R.S. Title 41, Chapter 6, Article 1 and Chapter 1, Article 1 of this Title.

Historical Note

Adopted as an emergency effective September 21, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-5). Emergency expired. Permanent rule adopted effective March 22, 1983 (Supp. 83-2).

R9-13-1002. Surface, air and water ambulance service general responsibilities

A. All ambulance services shall:

1. Display the ambulance service license at the place of business at all times and the license shall not be transferable.
2. Respond to all emergency medical situations when dispatched by a responsible party.
3. Use fresh and clean linen, cloth or disposable, including blankets for each patient transported. An adequate supply of fresh and clean linen, cloth or disposable, and blankets shall be maintained on the premises.
4. Clean and disinfect all equipment coming in contact with the patient.
5. Maintain the premises on which ambulances are parked, housed, docked or hangared in a sanitary manner.
6. Operate only those ambulances registered by the Department pursuant to Article 11 of these regulations.
7. Submit such forms on each patient transported as provided or approved by the Division.
8. Submit a written report of all ambulance accidents to the Division within five working days.
9. Submit such reports and other information as requested by the Division to assure compliance with these

regulations and A.R.S. § 36-2201 through A.R.S. § 36-2231.

B. Staffing requirements:
1. Unless otherwise specified in these regulations, while transporting a patient, each surface ambulance shall be staffed by not less than two certified ambulance attendants, one of whom must be in the patient compartment.
2. All ambulance services responding to an emergency medical situation shall assure that only licensed/certified medical personnel shall provide treatment of patients at the scene of the medical incident and during patient transfer.
3. An ambulance service shall notify the Division in writing of any change in employment of certified ambulance attendant personnel within 15 days of such change.

Historical Note
Adopted as an emergency effective September 21, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-5). Emergency expired. Permanent rule adopted effective March 22, 1983 (Supp. 83-2).

R9-13-1003. Air ambulance service general responsibilities

A. All air ambulance services shall: Have pilots and mechanics qualified by training and experience to operate and maintain air ambulances.
1. Have rotor wing pilots with commercial rotorcraft certification with a minimum of 2,000 rotorcraft flight hours as pilot in command. A pilot shall generally have at least 25 hours single engine and 50 hours multi-engine in the specific type of aircraft being used before being allowed to fly as a pilot in command on patient missions.
2. Have fixed wing pilots with a minimum of 2,000 fixed wing flight hours. A pilot shall generally have at least 50 hours in the specific type of aircraft being used before being allowed to fly as a pilot in command on patient missions.
3. Have a pilot, when IFR flights are made, with instrument certification with a minimum of 250 hours of instrument flight time, to include no more than 125 hours of simulated flight time.
4. Have rotor wing mechanics with at least two years experience as a licensed Airframe and Power plant mechanic. The mechanic shall be factory trained or equivalent on the specific type of aircraft before being allowed to work on that aircraft.

B. All ALS air ambulance services, other than neonatal, shall:
1. Have a physician as medical director who by training and experience is qualified in emergency, intensive and trauma care. The medical director shall:
   a. Supervise the quality of patient care provided by the medical flight crew.
   b. Provide medical direction and control for the medical flight crew.
   c. Act as liaison with emergency department physicians to assure continuity of care.
   d. Monitor and evaluate day to day operations of the air ambulance service.
   e. Provide individual consultation to medical personnel involved.
   f. Participate in the training of the medical personnel, including physicians when applicable.
2. Provide for the rapid transport of seriously ill or injured patients who require a high level of intensive care while en route.
3. Have a medical flight crew with specialized training in intensive and emergency care in the following areas:
   a. Advanced cardiac life support certification by The American Heart Association or other agency with substantially similar standards approved by the Division.
   b. Assessment and emergency care of shock and trauma, including multiple trauma, head injuries, burns and other injuries.
   c. Pediatric emergencies.
   d. Obstetrical emergencies.
   e. Behavioral and psychiatric emergencies.
   f. Altitude physiology.
   g. EMS communications.
   h. Aircraft and flight safety.
   i. All patient equipment on board the air ambulance.
4. Utilize and adhere to medical control plans adopted by the medical director. The medical control plans may include standing orders and shall include the following:
   a. Treatment protocols.
   b. Triage protocols.
   c. Communications protocols.
   d. Transfer protocols.
   e. Standing orders.
5. Meet the following training requirements:
   a. The medical director shall attest in affidavit form, supplied or approved by the Division, that the medical flight crew utilized as ambulance attendants are qualified and have had special training as air ambulance personnel pursuant to R9-13-1003(A)(3).
   b. The medical director shall implement 20 hours per year of continuing education in the areas set forth in R9-13-1003(A)(3).
   c. The medical director shall maintain records of training and continuing education on each ambulance attendant and such information shall be available at all times to the Director or his authorized representative.

C. All ALS neonatal services shall:
1. Require their medical director attest to neonatal flight nurses proficiency in neonatal resuscitation and general stabilization of the critically ill newborn. The curriculum shall be reviewed and approved by Arizona Department of Health Services. Neonatal nurses are not required to be ACLS certified.
2. Require neonatal nurses to have a minimum of two hours of Department approved special training in flight physiology and other special situations encountered in flight that may effect the physiologic functions of the patients and/or interfere with proper function of the medical equipment.
3. Require staffing of each ambulance with no less than one qualified neonatal nurse who must be in the patient compartment.
4. Utilize additional personnel, if necessary, to properly care for the medical needs of the patient. The choice and qualifications of such additional personnel shall be at the discretion of the medical director.

D. All BLS air ambulance services shall:
1. Staff each ambulance with no less than one air ambulance attendant who must be in the patient compartment.
2. Utilize additional personnel, if necessary, to properly care for the medical needs of the patient. The choice and qualifications of such additional personnel shall be at the discretion of the referring physician.

3. Designate a licensed physician who shall act as medical director for the service.
4. Implement ten hours per year of continuing education in the techniques of stabilization and transportation of emergency patients.
5. Maintain records of training and continuing education on each ambulance attendant and such information shall be available at all times to the Director or his authorized representative.
6. Not be utilized for the transportation of patients in need of Advanced Life Support services.

Historical Note
Adopted as an emergency effective September 21, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-5). Emergency expired. Permanent rule adopted effective March 22, 1983 (Supp. 83-2).

R9-13-1004. Water ambulance service general responsibilities

A. Water ambulance services shall not be utilized for transporting patients in need of Advanced Life Support services.

B. Patients in need of Advanced Life Support services shall be taken to the nearest level shore or roadway for continuous transportation by ALS air or surface ambulance.

C. All water ambulances shall comply with the Boating Code, A.R.S. §§ 5-301 through 5-391, and the provisions of The Arizona Game and Fish Boating rules, A.C.R.R. R12-4-501 through R12-4-599, and the following additional requirements:
1. The ambulance shall be at least 20 feet in length and 8 feet in width.
2. The ambulance shall have life preservers, type 1, for each person.
3. Patient's shall be transported in a litter that is equipped with flotation devices approved by the U.S. Coast Guard.
4. The ambulance shall have two type-2 hand portable fire extinguishers on board.

Historical Note
Adopted as an emergency effective September 21, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-5). Emergency expired. Permanent rule adopted effective March 22, 1983 (Supp. 83-2).

ARTICLE 11. AMBULANCE REGISTRATION CERTIFICATE

R9-13-1101. Registration certificate application procedures

A. Any person applying for an ambulance registration certificate shall:
1. Complete and submit an application using forms provided by the Division. The application shall contain the information required in R9-13-1001(B)(1).
2. Submit a check or money order payable to the Arizona Department of Health Services in the amount of $50 per ambulance.
3. Make each ambulance to be registered available for inspection prior to the issuance of a registration certificate.

B. Registration certificate provisions
1. The registration certificate shall not be transferable to any other ambulance.
2. The registration shall be prominently displayed within the ambulance.
3. The registration shall be valid from date of issue and must be renewed annually.

C. Certificate renewal application procedures. Any person applying for an ambulance registration certificate shall:
1. Complete and submit an application for renewal of an ambulance registration certificate to the Division not less than 30 days prior to expiration of current certificate to assure continuity.
2. Apply for renewal using forms provided by the Division and indicate compliance with the requirements as set forth for original registration, including ambulance inspections.
3. Submit a check or money order payable to the Arizona Department of Health Services, in the amount of $50 for renewal of the current registration certificate at the time of application.
4. Submit other information as requested by the Division to assure compliance with these regulations or applicable provisions of the law.

D. Termination of registration certificate
1. Prior to termination of ambulance service, the certificate holder shall give the Department 30 days' notice. Termination of service shall void the registration certificate.
2. A registration certificate issued under this Section terminates upon any change of ownership or control of a ambulance.
3. Following any change of ownership, the ambulance shall be registered by the new owner before the ambulance may again be operated in the state.

E. Suspension and revocation
1. Emergency suspension. Pursuant to A.R.S. § 41-1012(C) an ambulance registration certificate may be summarily suspended if the Division finds that the ambulance is not in compliance with the regulations in this Article and such non-compliance constitutes an emergency that imperatively requires immediate action to protect the health or safety of patients or attendants transported in the ambulance.
2. Suspension or revocation following a hearing
   a. After notice and opportunity to be heard is given according to the procedures described in A.R.S. Title 41, Chapter 6, Article 1 and in Chapter 1, Article 1 of this Title, a registration certificate may be suspended or revoked upon the following grounds:
      i. The certificate holder has in any way provided false information to the Division for the purpose of evaluation or registration.
      ii. That the certificate holder has failed to conform with the applicable requirements of A.R.S. Title 36, Chapter 21.1, Articles 1 or 2 and the regulations in this Article.
   b. If in the opinion of the Director, there is sufficient information indicating that the certificate holder has engaged in activities described in paragraph (1) of this subsection, the Director may request an informal interview with the certificate holder. If such invitation is refused, or if the interview is attended and the results indicate revocation of certificate might be in order, then a complaint may be issued and a formal hearing may be held in compliance with A.R.S. Title 41, Chapter 6, Article 1 and Chapter 1, Article 1 of this Title.

Historical Note
Adopted as an emergency effective September 21, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-5). Emergency expired. Permanent rule adopted effective March 22, 1983 (Supp. 83-2).

R9-13-1102. Ambulance design requirements

A. All ambulances shall:

1. Have access doors to the patient compartment of sufficient size to permit the safe loading and unloading of a person occupying a litter or stretcher, in the supine position, without interrupting life support measures.
2. Be temperature regulated to assure patient and attendant comfort.
3. Be equipped with appropriate operable lights and sirens for an emergency ambulance in accordance with Chapter 6, Article 2, A.R.S. § 28-624.
4. Only display ambulance markings that accurately reflect the level of care provided.
5. Be equipped with approved safety belts and anchorage for all occupants which shall comply with 49 CFR 571.208, 571.209 and 571.210.
6. Have sufficient lighting available for patient observation in the patient compartment.
7. Be equipped with a two way radio capable of direct communication with a hospital when transporting a patient. The radio shall be compatible with the state EMSCOM system established by A.R.S. § 41-1835.
8. Have an electrical system capable of supporting any auxiliary equipment on, or in, the ambulance without the threat of overload or system failure.

B. Minimum equipment and supply requirements

1. All responding ambulances shall contain the medical equipment and supplies recommended by the American College of Surgeons in "Essential Equipment For Ambulances", revised June, 1981, which is on file at the Department and a copy of which has been submitted to the Secretary of State.
2. In addition to the medical equipment and supplies required in paragraph (1) above, all ALS ambulances staffed by paramedics shall contain the following additional equipment:
   a. Defibrillator
   b. Electrocardiac monitor/tekenetry radio transmission
   c. Paramedic Drug Box approved by the Department, pursuant to R9-13-402(B)(4).
   d. Laryngoscope and assorted airway devices including endotracheal tubes.
3. All ambulances utilized to provide Advanced Life Support services shall contain the drugs required pursuant to the Arizona Department of Health Services Paramedic and IEMT Drug List, revised July 8, 1982, which is on file at the Department and a copy of which has been submitted to the Secretary of State.

Historical Note

Adopted as an emergency effective September 21, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-5). Emergency expired. Permanent rule adopted effective March 22, 1983 (Supp. 83-2).

R9-13-1103. Surface ambulance design requirements

In addition to the design requirements stated in R9-13-1102, surface ambulances shall meet or exceed the following minimum requirements:

1. The ambulance shall assure a smooth, stable ride, with nominal noise and vibration; with due consideration of road conditions. The ambulance shall be capable of rapid response and maximum acceleration to speed limits consistent with ambulance operation in traffic and on interstate highways.
2. The ambulance shall be capable of being driven for at least 150 miles without refueling under encountered environmental conditions.
3. The entire body, sides, ends and roof of the patient's compartment shall be insulated and sealed to reduce condition of heat or cold and to minimize external noise or contaminants from entering the ambulance interior.
4. Carbon monoxide (CO) levels within the cab or patient compartment of the ambulance shall not exceed a level greater than ten ppm above the ambient CO in the air.
5. The tires shall be of the same type, style, design, size and load range and may be tube or tubeless with regular highway tread of oversize, low-pressure design, offering optimal riding quality. Tires shall have a tread groove pattern depth of at least 4/32 of an inch when measured in a major treadgroove.
6. Each ambulance shall have one inflated spare wheel/tire assembly identical to those on the ambulance.
7. Each ambulance shall be furnished with tools required for changing spare mounted wheel/tire assembly, at any wheel with the tire flat. The jack, without blocking shall be capable of raising any wheel of the loaded ambulance to a height adequate to permit removal and replacement of the wheel/tire assembly.
8. Each ambulance shall be equipped with brakes in accordance with A.R.S. § 28-952.
9. Each ambulance shall be equipped with a horn and siren in accordance with A.R.S. § 28-954.
10. Each ambulance shall be equipped with a muffler in accordance with A.R.S. § 28-955. The exhaust shall discharge away from the fuel tank filler pipe(s) and door(s) to minimize fumes and contaminants entering the interior.
11. Each ambulance shall be equipped with rear vision mirrors in accordance with A.R.S. § 28-956.
12. Each ambulance shall be equipped with a windshield and windshield wipers in accordance with A.R.S. §§ 28-957 and 28-957.01. The windshield wiper system will include a water supply sufficient to maintain a clear windshield during transport of a patient.
13. The patient compartment of the ambulance shall be sufficient in size to transport occupants and accommodate all the stretchers, cots, and litters which the ambulance is designed to carry. There shall be space to permit a technician to administer life support treatment to at least one patient during transit.
14. Each ambulance shall provide a crash stable side or center mounting style fastener of the quick release type which shall secure the litter to the ambulance body.
15. Each ambulance shall provide adequate storage area or securing devices to prevent items from flying about the patient compartment while the ambulance is in motion or overturned.
16. The interiors of each ambulance shall be free of all sharp projections. All hangers or supports for equipment and devices shall be mounted as flush as possible with the surrounding surface when not in use. Padding shall be placed at all head area obstructions which may prove dangerous to persons moving about in the patient compartment.

Historical Note

Adopted as an emergency effective September 21, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-5). Emergency expired. Permanent rule adopted effective March 22, 1983 (Supp. 83-2).

R9-13-1104. Air ambulance design requirements

A. Fixed wing aircraft shall meet or exceed the following minimum requirements:

1. The aircraft shall have appropriate navigational radio and radar equipment for visual flight rules and, if necessary, instrument flight rules. Aircraft shall be equipped with radio headsets for all pilot crew members for intracockpit communication.
2. If the aircraft is to be used for the delivery of basic life support, the patient compartment design shall have sufficient space to accommodate at least one air ambulance attendant and one litter patient.
3. If the aircraft is to be used for the delivery of advanced life support care and techniques, the patient compartment design shall have sufficient interior space to accommodate at least one medical flight crew member with space for an additional attendant or medical technician, if indicated by the patient's condition, and one litter patient.
4. Safety belts shall be provided for all flight crew attendants. Safety and security restraints shall be provided for all equipment on board. Medical personnel shall be able to wear safety belts when working on the patient. The safety belt may be loosely attached to the attendant so as not to inhibit treatment of the patient.
5. If the aircraft is utilized for the delivery of neonatal life support and for the transportation of patients who require such care, transports shall be made in pressurized aircraft only. The interior design shall provide space for a minimum of one neonatal transport module and necessary life support equipment.
6. The cabin shall be large enough to allow unrestricted access to the patient while in flight by appropriate air ambulance attendants or medical flight crew members, as well as adequate room for medical equipment and supplies. The upper surface of the litter shall not be less than 24 inches from the ceiling of the aircraft, or the undersurface of another litter.
7. Ambulance shall be capable of pressurization for patient transport under medical conditions that require pressurization as determined by the air ambulance medical director under the Guidelines on Conditions Requiring Pressurized Aircraft set forth by the Arizona Department of Health Services, dated December, 1982, which is on file at the Department and a copy of which has been submitted to the Secretary of State.
8. Ambulances providing Advanced Life Support services shall have the following additional equipment:
   a. Ventilator equipped with a means of delivering positive-end-expiratory pressure.
   b. Transdermal PO_2 monitor.
   c. Intravenous infusion pump.

B. Air ambulance lighting and electrical power sources. All electrically operated medical equipment used on the aircraft shall have an external alternative compatible power source available.

C. Rotary wing aircraft shall meet or exceed the following minimum requirements:

1. Aircraft shall have appropriate navigational, radios, and radar equipment for visual flight rules and, if necessary, instrument flight rules. Aircraft shall be equipped with radio headsets for all crew members for intracraft communication.
2. If the aircraft is to be used for the delivery of basic life support, the patient compartment design shall have sufficient space to accommodate at least one air ambulance attendant and at least one litter patient with capability for provision of a second temporary litter. The second litter may be stored.
3. If the aircraft is to be used for the delivery of advanced life support care and techniques the patient compartment design shall have sufficient interior space to accommodate at least one medical flight crew member with space for an additional member if indicated by the patient's medical condition and at least one litter patient with the patient area so configured that advanced life support techniques may be performed for one person during transport.
4. Aircraft providing Advanced Life Support services shall have the following additional equipment:
   a. Ventilator equipped with a means of delivering positive-end-expiratory pressure.
   b. Transdermal PO_2 monitor.
   c. Intravenous infusion pump.
5. If the aircraft is utilized for the delivery of neonatal life support and for the transportation of patients who require such care, then the interior design shall provide space for a minimum of one neonatal transport module and necessary, life support equipment.

D. Rotary wing warning devices

1. Visible warning devices shall be installed on the underside of the aircraft to provide adequate day/night emergency warning.
2. Audible warning devices shall be installed to provide adequate and external voice communications.

E. Rotary wing lighting

1. The aircraft shall be equipped with a remote controlled search light.
2. The aircraft shall be equipped with a light that illuminates the tail rotor area.

F. Minimum equipment and supply requirements. All air ambulances shall contain the medical equipment and supplies recommended by the American College of Surgeons in "Air Ambulance Operations", dated February, 1980, which is on file at the Department and a copy of which has been submitted to the Secretary of State.

Historical Note

Adopted as an emergency effective September 21, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-5). Emergency expired. Permanent rule adopted effective March 22, 1983 (Supp. 83-2).

R9-13-1105. Water ambulance design requirements

All water ambulances shall:

1. Be of such design to permit safe operation of devices such as litters, stretchers, stokes basket, etc., entering or exiting the watercraft.
2. Be of such design that hull vibration and engine noise will not affect the patient or patient care.
3. Be equipped with a separate electrical driven motor and electrical system for emergency power if the main power source fails.
4. Have an electrical system capable of supporting any auxiliary equipment on, or in, the water ambulance without the threat of overload or system failure.

Historical Note

Adopted as an emergency effective September 21, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-5). Emergency expired. Permanent rule adopted effective March 22, 1983 (Supp. 83-2).

ARTICLE 12. MISCELLANEOUS

R9-13-1201. Waiver

A. Any of the provisions of these regulations relating to Ambulance Design Requirements as stated in R9-13-1102, R9-13-1103 and R9-13-1104, may be waived by the Director where the public need so requires and where such waiver will not endanger the health, safety and welfare of the public.

B. The waiver available under this rule is prospective in effect only, and, if a waiver is desired, it must be applied for in writing and granted in writing before any ambulance service or person may operate contrary to the Ambulance Design Requirements in R9-13-1102 through R9-13-1105.

Historical Note

Adopted as an emergency effective September 21, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-5). Emergency expired. Permanent rule adopted effective March 22, 1983 (Supp. 83-2).

R9-13-1202. Emergency expired

Historical Note

Adopted as an emergency effective September 21, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-5). Emergency expired (Supp. 83-2).

ARTICLE 13. ALS BASE HOSPITAL/IEMT CERTIFICATION

R9-13-1301. Supporting service agreements

A. A health care institution applying for certification as an ALS base hospital/IEMT shall provide for IEMT staffing through one of the following procedures.

1. The health care institution shall employ and pay wages or salaries of IEMT's through its regular payroll procedures.
2. The health care institution shall provide, through a written agreement with an agency authorized to provide IEMT services pursuant to A.R.S. § 36-2201, for both on-line medical supervision and administrative medical direction of IEMT's employed by such agency.

B. A health care institution applying for certification as an ALS base hospital/IEMT shall submit to the Department written documentation that:

1. An emergency vehicle unit will be available whenever possible, staffed by IEMT's for the purpose of delivering emergency medical care to the sick and injured at the scene of an emergency. Such vehicle need not be physically based at the ALS base hospital/IEMT.
2. Emergency vehicle units assigned to the applicant ALS base hospital/IEMT shall not be assigned concurrently to any other facility for administrative medical direction of the IEMT's staffing the unit.
3. On-line medical supervision will be exercised according to specific procedures consistent with these regulations.
4. When ALS skills have been instituted, an IEMT will remain with the patient until transfer of care to the staff of an emergency receiving facility, ALS base hospital/ IEMT, or another comparably staffed ALS equipped emergency vehicle unit.
5. There will be prompt replenishment of, and compensation for, medical and pharmacy supplies expended by IEMT's during treatment of a patient who is transported to any facility.
6. All individuals who function as the ALS base hospital/ IEMT medical control authorities or intermediaries receive at least 24 hours per year experience on emergency vehicle units in order to gain pre-hospital experience, to observe pre-hospital conditions and procedures.
7. On-going evaluation, monitoring, and continuing education of IEMT's is provided by the ALS base hospital/IEMT and its medical control authorities.

C. A health care institution applying for certification as an ALS base hospital/IEMT may enter into agreements with ALS system hospitals for the administrative medical direction of IEMT's assigned to the applicant for on-line medical supervision. Such agreements shall provide that all on-line supervision of IEMT's shall be accomplished by the applicant facility and shall also provide for:

1. Assignment of IEMT emergency vehicle units to ALS system hospitals for purposes of monitoring continuing education, and pre-hospital care review.
2. Appointment of pre-hospital care medical director and registered nurse coordinator from the ALS system hospital who are responsible for supervising pre-hospital activities.
3. Prompt replenishment of ALS supplies and medications at the ALS system hospital.
4. Participation by the ALS system hospital medical director as a member of applicant facility's pre-hospital care committee.
5. A physician to be present and ready to assume patient responsibility in the ALS system hospital emergency department within 15 minutes of notification.
6. Adherence by the ALS system hospital to medical control plans adopted by the ALS base hospital/IEMT and the local EMS coordinating system.

Historical Note

Adopted effective November 23, 1983 (Supp. 83-6).

R9-13-1302. Responsibilities and requirements

A. An applicant for certification as an ALS base hospital/IEMT shall:

1. Submit a written endorsement of the hospital's application by the hospital's governing board or board of trustees which reflects the consideration of the medical staff, including the emergency department medical director.
2. In regions where a local emergency medical services coordinating system has been designated, submit written documentation of that system, which includes comments on the appropriateness of the application in regards to that system's plan for medical control of advanced life support.

B. Staffing requirements. ALS base hospitals/IEMT shall:

1. Have physically present at all times in the emergency department, an emergency physician who functions as the medical control authority.
   a. Such physician shall be knowledgeable of the capabilities and limitations of IEMT's, as well as established standing orders, treatment, triage, and communications protocols.
   b. The emergency physician shall designate an emergency department nurse or emergency physician's assistant who may function as an intermediary for on-line medical supervision under the direction of the emergency physician.
2. Identify as ALS base hospital/IEMT medical director an emergency physician who is responsible for administrative medical direction of the IEMT base and pre-hospital care personnel.
3. Appoint an emergency physician, emergency department nurse, certified emergency paramedic or emergency

physician's assistant to act as coordinator for all ALS pre-hospital activities and responsibilities of the ALS base hospital/IEMT.

C. Operating procedures. An ALS base hospital/IEMT shall:
1. Procure operational radio equipment, compatible with the Department of Public Safety Statewide EMS Communications Systems and any local EMS communications system approved by the Department of Public Safety. Such equipment shall be located in the emergency department for the purpose of providing direct communication with IEMT's.
2. Provide a dedicated telephone line for pre-hospital emergency care personnel to contact the ALS base hospital/IEMT's.
3. Immediately communicate all pertinent patient management information to the responsible physician or nurse at the receiving facility when a patient is to be transported to another receiving facility. If the receiving facility is also a certified ALS base hospital/IEMT, care of the patient and direct communication with IEMT's rendering that care may be transferred to the receiving medical control authority at the discretion of the sending medical control authority.
4. Utilize and adhere to the medical control plans adopted by the local EMS coordinating system. In regions where no medical control plans have been adopted, plans provided by the Department at the recommendation of the Emergency Medical Services Council shall be utilized. The medical control plans shall include standing orders and shall include the following:
   a. Treatment protocols.
   b. Triage protocols.
   c. Communication protocols.

D. Quality control and education commitment. An ALS base hospital/IEMT shall:
1. Provide for supervised clinical training for IEMT continuing education.
2. Assist with, or conduct, continuing education programs as required for IEMT recertification.
3. Provide monthly a minimum of two hours of formal pre-hospital care review and pre-hospital care continuing education for emergency physicians, nurses, and IEMT's.
4. Appoint a pre-hospital care committee consisting of a representative of the ALS base hospital/IEMT medical director, the ALS base hospital/IEMT coordinator, an emergency physician, an emergency department registered nurse, an administrative representative, an IEMT, and an IEMT employer representative. This committee shall:
   a. Ensure that the medical, administrative, emergency physician, and nursing staffs are oriented to the program.
   b. Establish and implement a system for evaluating the results of IEMT responses and auditing the quality of medical care provided.
   c. Establish and implement a system for identifying continuing educational needs of IEMT's.
   d. Assure case reviews of every IEMT encounter carried out under on-line medical supervision.
   e. Establish and implement a written procedure which will identify methods for resolving problems which may arise concerning the performance, competence, and medical inter-relationships of IEMT's, emergency physician's assistants, emergency department nurses, and emergency physicians.

E. Reporting requirements. An ALS base hospital/IEMT shall:
1. Submit monthly reports and requested information to the Department on forms approved by the Department.
2. Cooperate with and assist the Department in collecting statistics and evaluating performance and costs relating to utilization of IEMT's.

F. Term of certification and recertification
1. Application for certification and recertification as an ALS base hospital/IEMT shall be made to the Department on forms specified by the Department.
2. Certification as an ALS base hospital/IEMT shall be for a period of two years provided that the conditions of A.R.S. § 36-2201 et seq. and this Article are met throughout the certification period.
3. Application for recertification shall be submitted at least 90 days prior to the expiration date of the current certification.

Historical Note
Adopted effective November 23, 1983 (Supp. 83-6).

R9-13-1303. Suspension and revocation

A. After notice and opportunity to be heard is given according to the procedures described in A.R.S. Title 41, Chapter 6, Article 1 and in Chapter 1, Article 1 of this Title, certification may be suspended or revoked upon the following grounds:
1. That the ALS base hospital/IEMT has in any way provided false information to the Department for the purpose of evaluation or certification.
2. That the ALS base hospital/IEMT has failed to conform with the applicable requirements of A.R.S. Title 36, Chapter 21.1, Article 1 or the regulations in this Article.

B. If, in the opinion of the Director, there is sufficient information indicating that the ALS base hospital/IEMT has engaged in the activities described in subsection (A), the Director may request an information interview with the medical director of the ALS base hospital/IEMT concerned. If he refuses such invitation, or if the interview is attended and if the results of such interview indicate suspension or revocation of certification is warranted, then proceedings may be initiated as provided by A.R.S. Title 41, Chapter 6, Article 1 and Chapter 1, Article 1 of this Title.

Historical Note
Adopted effective November 23, 1983 (Supp. 83-6).

ARTICLE 14. REGULATION OF AMBULANCES AND AMBULANCE SERVICES

R9-13-1401. Definitions

A. When used in this Article, words defined in A.R.S. § 36-2201 and in R9-13-1401, shall have the same meaning herein.

B. In this Article, unless the context otherwise requires:
1. "Affected region" means the total geographical area of the service areas of all ambulance services that operate within or adjacent to the service area concerned.
2. "Air ambulance" means an ambulance that is designed and manufactured to travel by air, and includes fixed-wing aircraft and helicopters.
3. "Applicant" means the person seeking a Certificate of Necessity under this Article.
4. "Base rate" means a flat rate charge based on level of service performed by a land or water ambulance service.
5. "Central operations station" means the physical facility or airport at which an ambulance service conducts its principal, or most substantial part of its ambulance service operations within the service area granted under its Certificate of Necessity.

6. "Certificate holder" means the person to whom a Certificate of Necessity is issued.
7. "Certificate of Necessity" means a certificate issued to an ambulance service by the Department pursuant to Article 2, Chapter 21.1 of Title 36, Arizona Revised Statutes which describes, but is not limited to, its service area, central operations station, and any sub-operations station.
8. "Change" means an action or occurrence by which a situation relevant to licensure has become distinctly and materially different so that it can reasonable be expected that the ambulance service does not or will not conform to the conditions of its current Certificate of Necessity.
9. "Change of service area of sub-operation station" means a change involving a relocation of ambulances, related equipment, and personnel housed at one location for housing at another location so that it is no longer possible for the ambulance service making the change to conform to the conditions of its Certificate of Necessity regarding its designated service area.
10. "Communications base" means the location at which equipment is housed for use in two-way communications with ambulance or medical facilities and which controls the dispatch of ambulances and personnel of an ambulance service.
11. "Disaster" means a sudden major catastrophe or emergency or other temporary condition determined to have resulted or to be likely to result in such widespread damage and such mass casualties or threats to the health and safety of members of the public that available ambulance services cannot reasonably be considered adequate to respond to the emergency needs of the affected public.
12. "Mileage charge" means the rate assessed by a surface or water ambulance service, measured in miles from the point at which the ambulance receives the patient to the point of final destination (loaded miles). When charges are to be computed for part of a mile, a fraction of a mile of 4/10 or less will be rounded off to the last whole mile and a fraction of a mile of 5/10 or more will be rounded off to the next whole mile.
13. "Patient" means an individual who is sick, injured, wounded or otherwise incapacitated or helpless.
14. "Response Time" means the actual elapsed time between notification of a request for service by an ambulance service and the arrival of the ambulance at the point of patient origin.
15. "Service area" means the geographic area served by an ambulance service within the response times established and which the ambulance service has been granted authority to serve in its Certificate of Necessity.
16. "Stand-by rate or waiting charge" means the rate assessed by a surface or water ambulance service, on an hourly basis or fraction thereof, when a surface or water ambulance is held in excess of 15 minutes to load or 15 minutes to unload or for the convenience of the patient or for other authorized reasons through no fault of the ambulance service or except as may be otherwise defined by a contract between the ambulance service and the patient or his third party payor.
17. "Sub-operation station" means a physical facility or airport at which an ambulance service conducts operations for the dispatch of ambulances and personnel, other than at its central operations station, and which is within its service area granted under its Certificate of Necessity.
18. "Variance" means permission granted by the Department, for a time-limited period not exceeding 120 days, to comply in a manner other than that generally specified in a specific regulation.
19. "Waiver" means permission granted by the Department not to comply with a specific regulation.

Historical Note

Adopted as an emergency effective November 29, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Former Section R9-13-1403 renumbered and amended as permanent rule R9-13-1401 effective March 19, 1984 (Supp. 84-2).

R9-13-1402. Application for Certificate of Necessity

A. Initial application. Each applicant for a Certificate of Necessity shall file an application with the Department in duplicate on a form prescribed and provided by the Department, which shall include, at a minimum, the following categories of information to allow a determination if public necessity requires the service or any part of the service proposed, if response times are adequate, and if proposed rates and charges are reasonable:

1. The names, addresses, and telephone numbers of the following:
   a. Applicant (who shall be the owner of the ambulance service or an individual to whom he has given a power of attorney to apply for a Certificate of Necessity or other related ambulance service matters).
   b. If a corporation, the principal stockholders (10% or more stock).
   c. All officers, if a corporation.
   d. Individual who maintains or will maintain books, records, and other data.
   e. Medical director or medical advisor of the service and base hospital or affiliated medical facility, if any, if IEMT or ALS level service will be offered.
2. Type of business (individual, partnership, corporation, other -- specify).
3. The type and identification of the entity responsible for operation, if different from ownership.
4. The trade name or other name, if any, under which the applicant does business or proposes to do business.
5. The address of the central operations station and any sub-operation station(s).
6. A declaration and complete description of all of the geographic boundaries of the proposed area that the applicant intends to serve as an ambulance service and for which it seeks authority. Such a service area may contain one or more sub-operation stations within its proposed geographic service area. An applicant shall affirmatively substantiate the reasonableness of the service area for which approval is sought according to the following considerations:
   a. The average and maximum probable response time in good and severe weather from its proposed central operations station to the most distant boundary in its service area; or, if the applicant's service area is to contain one or more sub-operation stations, the average and maximum probable response time in good and severe weather from its central operations station within its service area and any sub-operation station to the points most distant from any operation station, central or sub.
   b. The projected distances to be traveled to provide such service.

c. If other ambulance service providers already operate in all or part of the service area requested in the application, the applicant shall also file a statement describing why the proposed service would be in the best interest of the public.
d. The statement required by subparagraph (c) shall be complete, and it shall be prepared with the objective of realistically informing the Department.

7. Back-up coverage, including reserve ambulance(s) available to the applicant, and any signed mutual aid agreements with neighboring providers.
8. Actual past and estimated future utilization of ambulances, related equipment and personnel.
9. The location of the communications base and a description of the communications equipment in the applicant's ambulances and in its communications base.
10. A listing and description of all ambulances to be used by the ambulance service.
11. Basic actual or estimated financial data, including:
    a. Balance sheet, operating or income statement, and a statement of changes in financial position.
    b. Revenue or income (Actual and in-kind).
    c. Actual or projected schedule of rates and charges.
    d. Sources of revenue by type.
    e. Expenses by category.
    f. Listing of all capitalized ambulance equipment (depreciation schedule).
    g. Copies of ambulance service contracts and subscription service contracts.
    h. Purchase or lease agreements on real estate, ambulances, and equipment items exceeding $5,000,00.
    i. Copies of federal and state grants or contracts.
    j. Other sources and amounts of financial assistance.
    k. Copies of insurance policies.
    l. Balance sheet and income statement on other affiliated business activities when they relate directly or indirectly to ambulance service operations.
12. Statement by applicant as to work experience and qualifications to operate an ambulance service and to why the Department should find that applicant to be a fit and proper person.
13. Statement by applicant if ever convicted of a felony or a misdemeanor involving moral turpitude or if applicant has ever had an ambulance service certificate or license suspended or revoked by any state or municipality. If "yes" to any of these items, provide an explanation in the statement.

B. Change of service application. Each applicant requesting a change in its approved service area, central operations station or any sub-operation station or the establishment of a new sub-operation station shall include, at a minimum, the following additional categories of information:

1. A description and justification of the proposed change in service area, central operations station or sub-operation station or any new sub-operation station.
2. A description of the geographic features of the service area that have a direct bearing on the proposed service or modified service.
3. A statement of all costs associated with the change(s) requested, including any capital costs, operating costs, equipment or personnel costs, projected patient charges for at least one year, and any other related information or data.

C. Renewal application

1. The Department will notify the ambulance service of the need to renew its Certificate of Necessity approximately 100 days prior to the expiration date of the then current Certificate of Necessity. Renewal applications shall be submitted on a form prescribed and provided by the Department.
2. The ambulance service shall file the renewal application with any required exhibits and fees at least 60 days prior to the expiration date of the Certificate of Necessity to be renewed in order to allow for needed processing and review by the Department.
3. If an ambulance service fails to file a timely application for renewal of its Certificate of Necessity or is not granted a renewal Certificate of Necessity, it shall cease all ambulance service operations in this state on and after the expiration date of its Certificate of Necessity. To commence operations again, an ambulance service must file a new application, pay required fees, and meet all other requirements for a Certificate of Necessity as though the owner were an original applicant before the Department.

D. Applicants will be required to furnish such other information as may be needed by the Department to clarify incomplete or ambiguous information contained in the application or in any documents filed with the application.

E. The application shall contain or be accompanied by a written declaration that it, and any documents filed with the application, is made under penalties of perjury.

F. The ambulance service applicant shall pay those fees specified in A.R.S. § 36-2240 to the "Arizona Department of Health Services" by certified funds (money order, cashier's check, bank draft), at the time an application is filed.

G. If the Department determines that an applicant has failed to reasonable comply with filing requirements, the Department shall either:

1. Dismiss the application by written order and state its reasons therein, or
2. Return the application and any documents filed with the application, with a statement containing its reasons therefor, and allow the applicant a reasonable period of time within which to comply, but not to exceed 30 days.

Historical Note

Adopted as an emergency effective November 29, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Former Section R9-13-1404 renumbered and amended as permanent rule R9-13-1402 effective March 19, 1984 (Supp. 84-2).

R9-13-1403. Hearings; general provisions

A. All required public hearings will be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 1 and Chapter 1, Article 1 of this Title.

B. There will be one public hearing regarding any ambulance to ambulance service matter or action. Such hearings may continue for more than one session.

C. Applications or actions regarding Certificates of Necessity of more than one ambulance service within any service area may be considered at the same public hearing.

D. Any interested person, including the Department staff, may attend a hearing and offer oral or written testimony or other evidence relevant to the application or referenced in the Notice of Hearing.

E. The scope of the testimony and evidence offered and questions asked shall be confined to the application of anything referenced in the Notice of Hearing.

F. Decisions and orders of the Director will rest on facts and evidence presented at the hearing.

G. The record of each hearing before the Department will be preserved for a period of three years and will be made available for examination upon request.

Historical Note
Adopted as an emergency effective November 29, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Former Section R9-13-1405 renumbered as permanent rule R9-13-1403 effective March 19, 1984 (Supp. 84-2).

R9-13-1404. Certificate of Necessity; term; posting; general provisions

A. Term
1. An initial Certificate of Necessity issued to an ambulance service shall be for a term of one year and shall expire on the last day of the 12th month following the date issued.
2. If the holder of a Certificate of Necessity timely applies for a renewal and has met all required conditions and paid the fees prescribed, the Director will renew the Certificate of Necessity for a term not to exceed three years, unless good cause for refusal or renewal for a shorter term has been determined by the Director.

B. Posting. Any Certificate of Necessity, or a copy thereof, issued by the Department, shall be posted in a conspicuous place in the central operation station and any sub-operation station of the ambulance service.

C. General provisions
1. One Certificate of Necessity will be issued to an ambulance service for each service area and for each sub-operation stations within the service area granted by the Director.
2. A Certificate of Necessity is valid when signed by the Director and on the date shown on its face.
3. Every Certificate of Necessity issued by the Department will identify the approved service area, central operations station, and any sub-operation station(s). No ambulance service shall expand its service area, change its central operations station and any sub-operation station, or establish any new sub-operation station without the prior approval of the Department and the issuance of a new or amended Certificate of Necessity. Failure to comply with this provision may result in an action to cancel the Certificate of Necessity.
4. The Department may issue a Certificate of Necessity as applied for, or may issue it for only part of the ambulance service proposed, as determined necessary by the Director.
5. A new or an amended Certificate of Necessity will be issued by the Department following an approval of any matters relating to service area, central operations station or sub-service area stations.
6. The Director may issue a Certificate of Necessity to more than one ambulance service within the same service area if the Director deems that such action is in the public's best interest. In doing so, factors which the Director may consider include:
   a. Application and any accompanying documents and statements.
   b. Population density.
   c. Geographic distribution of hospitals.
   d. Number of requests for ambulance service per month within service area.
   e. Response times.
   f. Utilization of ambulances, support equipment and personnel.
   g. Cost of operations and net profits.
   h. Adequacy of existing ambulance service(s) in the service area.
   i. Records and data on file with the Department.

Historical Note
Adopted as an emergency effective November 29, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Former Section R9-13-1406 renumbered and amended as permanent rule R9-13-1404 without change effective March 19, 1984 (Supp. 84-2).

R9-13-1405. Transfer of ambulance service

A. Whenever a transfer of an ambulance service is proposed or upon any change in type of business entity (e.g., individual to partnership or corporation; partnership to individual or corporation) or change in ownership or control of the ambulance service, a written request for approval to transfer a Certificate of Necessity shall be made to the Department together with appropriate fees and exhibits and shall be executed by both parties.

B. The Department will give notice of a hearing regarding any written request to transfer an ambulance service or change in type of business entity or in ownership or control of the ambulance service.

C. If, after hearing on a written request to transfer an ambulance service, the Director finds that the transaction proposed will be consistent with the public interest, such transfer will be approved.

D. If a license terminates pursuant to A.R.S. § 36-2212(C) the Certificate of Necessity issued to the current ambulance service shall remain in effect for a period, not to exceed 90 days, to allow a written request to transfer a Certificate of Necessity to be granted or denied by the Director.

E. When any Certificate of Necessity is approved to be transferred, the Director will issue to the transferee a new certificate that is valid only for the unexpired term of the transferred certificate.

Historical Note
Adopted as an emergency effective November 29, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Former Section R9-13-1407 renumbered and amended as permanent rule R90-13-1405 effective March 19, 1984 (Supp. 84-2).

R9-13-1406. Suspension and revocation

A. After notice and opportunity to be heard is given according to the procedures described in A.R.S. Title 41, Chapter 6, Article 1 and in Chapter 1, Article 1 of this Title, a Certificate of Necessity may be suspended or revoked for the following reasons:
1. That the certificate holder has provided false information to the Department:
   a. For the purpose of the evaluation of an application for a Certificate of Necessity.
   b. Regarding any matters relating to its ambulance and ambulance service operations.
2. That the certificate holder has failed to:
   a. Conform with the applicable requirements of A.R.S. Title 36, Chapter 21.1, Articles 1 and 2 or applicable regulations in this Article.
   b. Comply with its Certificate of Necessity and any schedule of rates and charges filed with and approved by the Department.

c. Meet its established response times.
d. Maintain required insurance or financial responsibility.
e. Submit prescribed reports on a timely basis.

B. Before a person may commence operations again, after revocation of a Certificate of Necessity by the Department, for whatever valid reason, the person shall file an application, pay required fees, and meet any other requirements of the Article the same as though the owner were an original applicant before the Department requesting authority to operate an ambulance service in this state.

Historical Note
Adopted as an emergency effective November 29, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Former Section R9-13-1408 renumbered and amended as permanent rule R9-13-1406 effective March 19, 1984 (Supp. 84-2).

R9-13-1407. Abandonment or discontinuance of service

A. An ambulance service desiring to abandon or discontinue any service or portion thereof, shall submit a written request to the Department which shall state in detail the justification for the proposed abandonment or discontinuance of ambulance service.

B. The Department will not authorize abandonment or discontinuance of an ambulance service or any portion thereof except for good cause or where services to the public will not be adversely affected.

Historical Note
Adopted as an emergency effective November 29, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Former Section R9-13-1409 renumbered and amended as permanent rule R9-13-1407 effective March 19, 1984 (Supp. 84-2).

R9-13-1408. Rates and charges; exemption; rate increase; filing and posting of schedule

A. Exemption. Air ambulance services are exempt from the filing of a schedule of rates and charges with the Department. However, as a matter of good business practices and courtesy to the public, an air ambulance service granted a Certificate of Necessity by the Department should publish and keep available to the public at its central operation station and at each sub-operation station, a schedule showing its rates and charges, and any operating rules and regulations. Any such document published by an air ambulance service shall also be filed with the Department.

B. Ambulance service contracts. All contracts, except those contracts with a federal agency, regarding the providing of ambulance and ambulance service will be approved by the Director and may require a public hearing to determine or alter rates or charges, or other provisions or to determine if any rate or charge is unjust, unreasonable, or non-compensatory, unless the provisions specified in A.R.S. § 36-2234(C) or (D) apply. The Director's approval will be conditioned upon a finding that any rates or charges, or other provisions specified in the contract shall not cause any fixed rate or charge to the general public to be adversely affected.

C. Unauthorized charges or services. When complaint is made to the Department concerning any rate or charge or any rule or regulation established for any ambulance service, and after investigation the Department determines that the ambulance service has made unauthorized charges or services, the Department will request that the ambulance service make reparation to the complainant. If the ambulance service does not comply with the request of the Department, the Department may set a public hearing to determine whether the ambulance service should make reparation to the complainant and to determine if the ambulance service is fit and proper person. The provisions of this subsection also apply if, during an inspection by a representative of the Department of the records and books of an ambulance service, it is discovered that any unauthorized charges or services were provided

D. Request for rate increase.
1. Filing of request. An ambulance service which is seeking a rate increase shall:
   a. State the reasons why the rate increase is needed and what specific areas and cost changes are involved.
   b. Bear the burden of proof as to the need for a rate increase.
   c. Provide a sworn statement that to the best of its knowledge, the financial statement, documents, or exhibits being filed are true, correct and complete and have been prepared from the books and records of the ambulance service.
2. Filing of operating statements, documents, and exhibits. Any ambulance service that requests an increase in any rate or charge in excess of the GNP Price Deflator as defined in A.R.S. § 41-563, subsection (E), shall file the following minimum financial statements and information with the Department:
   a. A balance sheet.
   b. Income statement.
   c. A statement of changes in financial position.
   d. A projected revenue and expense statement that reflects proposed increases or decreases in revenues and any known actual or substantiated projected increases or decreases in expenses.
   e. Copy of most recent audit report if the ambulance service has been audited by a Certified Public Accountant (CPA).
   f. A summary of revenue by approved rates and charges.
   g. A schedule of any other services provided by the ambulance service under the same business structure.
   h. Depreciation schedules.
   i. Net purchase cost of supplies and equipment which are generally used in an ambulance in providing treatment to patients, together with the proposed percent of markup.
   j. Any other documents or exhibits that would support the need for a rate increase.
3. Other filing provisions.
   a. The Department may request additional information and data in order for it to make a proper review, to clarify incomplete or ambiguous information, and make an informed decision.
   b. The Department reserves the right to review and audit the financial records and books of an ambulance service.
   c. Financial reports and information provided to the Department shall cover a one-year period and shall be filed with the Department no later than 120 days after the end of the report year utilized.
   d. Cost increases reflected in any document or exhibit that are filed with the Department should be stated in both a dollar amount and a percentage of increase and reflect only known actual cost increase or substantiated projected increases. The Department will not give weight to any future inflationary expectations.

e. Should the Department request additional information and documents and the ambulance service fails to comply with the request by the set filing date, the Department will dismiss the request for a rate increase without a written order or hearing and return all filings to the ambulance service on the basis that the Department does not have sufficient information or data or that the information or data on hand is no longer current in order for the Department to make an informed decision.

E. Rate setting considerations. When establishing appropriate and reasonable rates and charges the Director may consider the following factors:
1. The necessary direct and indirect actual expenditures in providing ambulance services.
2. The balance sheet.
3. The income statement.
4. The ratio between variable and fixed costs.
5. Increases or decreases in the GNP Price Deflator (A.R.S. § 36-2234(C)(4).
6. The method of indirect cost allocation to specific cost center areas.
7. The return on the owner equity.
8. Reimbursable and non-reimbursable charges.
9. Records and data on file with the Department.

F. Fixed rates or charges. The schedule of rates or charges fixed by the Director shall include the following general classifications:
1. Base rate for basic life support (BLS) by an ambulance service.
2. Base rate for advanced life support (ALS) by an ambulance service.
3. Stand-by or waiting charge.
4. Mileage rate.
5. Accessorial equipment service and medical supply items.

G. Filing of schedule of rates and charges.
1. An ambulance service shall file its schedule of fixed rates and charges with the Department.
2. No increase shall be made by any ambulance services in any rate or charge unless and until the new fixed increases have been filed with and approved by the Department by issuance of a new or amended schedule or by page change.
3. A schedule of rates and charges required to be filed under paragraphs (1) and (2) shall include, as a minimum, the following schedules, rules and regulations:
   a. A schedule printed in legible type containing a detailed listing of all services and items for which a separate charge will be made to each patient.
   b. A copy of all rules and regulations which may in any way change, affect or determine any part or the aggregate of the rates or charges fixed by the Director or the value of the services or supply items covered by the schedule.
   c. Title page
   d. Check sheet page
   e. Table of contents page
   f. A description of the service area, central operations station, and any approved sub-operation station, as granted by the Department.
   g. Section on accessorial equipment service and medical supply items and their approved charges.
   h. Section on approved ambulance service rates.
   i. Explanation of abbreviations and reference marks page.
4. The rates or charges fixed by the Director shall take effect on the date that a proper schedule or an amended schedule or page change is filed with the Department or on such later date as may be specified on the schedule. The order issued by the Department granting any increase or change will be so noted on the schedule.
5. Any approved change in a schedule shall be so marked by an abbreviation or reference mark preceding or following the item.

H. Posting of schedules. Each ambulance service shall post and maintain at all times, for public inspection, in a conspicuous place at its central operations station and at any approved sub-operations station, a copy of the current schedule approved by the Department. The schedule must have an issue stamp of the Department to be official. When requested, the ambulance service shall assist interested persons to understand the content, provisions, and rates and charges contained in the schedule.

Historical Note

Adopted as an emergency effective November 29, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Former Section R9-13-1410 renumbered and amended as permanent rule R9-13-1408 effective March 19, 1984 (Supp. 84-2).

R9-13-1409. Insurance or financial responsibility

A. To protect the interests of the public, ambulance services shall maintain at all times in force and effect minimum liability and malpractice insurance coverage of $1,000,000.

B. A copy of every Certificate of Insurance or other satisfactory evidence of insurance coverage shall be filed with the Department and shall be executed by an insurance company that is authorized to transact business in this state.

C. The liability insurance policy or policies shall bind the insurer to pay compensation for injuries to persons and for loss or damage to property resulting from the negligent operation of an ambulance service or by reason of the ownership, maintenance or use of any ambulance owned or operated by the ambulance service.

D. The Director will revoke the Certificate of Necessity of any ambulance service which fails to comply with this rule or any other applicable federal or state laws regarding insurance or financial responsibility.

E. Before a person may commence operations again, after revocation of its Certificate of Necessity, the person shall file an application, pay required fees, and meet any other requirements of this Article the same as though the owner were an original applicant before the Department requesting authority to operate an ambulance service in this state.

Historical Note

Adopted as an emergency effective November 29, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Former Section R9-13-1411 renumber and amended as permanent rule R9-13-1409 effective March 19, 1984 (Supp. 84-2).

R9-13-1410. Required records; reports and data; inspection

A. Required records
1. An ambulance service shall maintain for review and inspection by the Department, the following records, books and other data:
   a. Balance sheet and income statement and all source documentation (business papers) supporting entries to these two financial statements.
   b. Federal and state income tax documents and supporting records.

c. Employee related expense reports and records and time-keeping records.
d. Bank statements and canceled checks.
e. Notes and bad debt records.
f. Depreciation schedules or accounting records on service vehicles, service support equipment, office furniture, and other plant and equipment assets.
g. Ambulance run tickets and related documents.
h. Billings and supporting documents.
i. Dispatch logs.
j. Contracts, grants, and financial assistance records relating to any and all ambulance and ambulance service operations.

2. At each office where records are maintained or stored the records shall be arranged so that they may be readily identified and made available to the Department representative(s).
3. Every ambulance service shall protect required records from fires, flood, and other hazards and safeguard the records from unnecessary deterioration.
4. If any required record, book, and other data is destroyed or lost before the prescribed period, a statement shall be prepared, listing as accurately as possible, the records destroyed or lost and describing the circumstances under which they were destroyed or lost. The statement shall be certified by the owner or a principal officer of the ambulance service company.
5. The records referred to in this regulation may not be destroyed after an ambulance service is totally discontinued and completely liquidated unless the required retention period has lapsed. If an ambulance service is merged with or transferred to another ambulance service under jurisdiction of the Department, the successor shall preserve records of the other ambulance service for the retention period specified.

B. Reports and data. Every ambulance service shall file with the Department reports of earnings and expenses, financial information, statistical reports and data as may be deemed necessary for purposes of evaluating the operation of ambulances and ambulance service in this state.

C. Inspection of records

1. When requested by the Department, an ambulance service shall provide to the Department copies of any records, books and other data in its possession, or in any way relating to or affecting its ambulance services.
2. The Director or his appointed representative(s) may, at any time during usual business hours, inspect the records, books, accounts, papers and documents, and other data of an ambulance service to verify their truth and accuracy. If any required records are maintained outside of this state, the ambulance service shall, upon request by the Director, make the records available at a location within this state designated by the Director. If the required records are maintained outside of this state and will not be made available at the Director's designated location, the Director shall require the ambulance service to whom a reasonable records request has been made to pay in advance subsistence and travel expenses for the Director's appointed representative(s) to conduct an examination of the records.

Historical Note

Adopted as an emergency effective November 29, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Former Section R9-13-1412 renumbered and amended as permanent rule R9-13-1410 effective March 19, 1984 (Supp. 84-2).

R9-13-1411. Recordkeeping methods and accounts

A. Each ambulance service shall establish and maintain a uniform system and classification of accounts.

B. To carry out the provisions of A.R.S. § 36-2232 et seq. and this regulation, the generally accepted accounting principles and concepts established by the American Institute of Certified Public Accountants (AICPA) or issued by the Financial Accounting Standards Board (FASB) will serve as the guide in measuring, recording, and reporting the financial affairs and activities of an ambulance service.

Historical Note

Adopted as an emergency effective November 29, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Former Section R9-13-1413 renumbered and amended as permanent rule R9-13-1411 effective March 19, 1984 (Supp. 84-2).

R9-13-1412. Fees for copying; fees not refundable

A. Certifications and copies. Certifications and copies of such public records and documents on file with the Department, as may be practicable to furnish, will be furnished on the following basis:

1. $1.00 for each document to be certified.
2. $0.25 for each page or partial page for making copy of document, with a minimum charge of $1.00 for such service.

B. Fees not refundable. After an application for a Certificate of Necessity or an application to amend, transfer or renew a Certificate of Necessity has been accepted for filing by the Department, the filing fee will not be refunded, regardless of whether the application is granted or approved, denied, dismissed, or withdrawn. However, if an application is rejected by the Department at the time of filing as incomplete or for some other reason, the fee will be returned.

Historical Note

Adopted as an emergency effective November 29, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Former Section R9-13-1414 renumbered and amended as permanent rule R9-13-1412 effective March 19, 1984 (Supp. 84-2).

R9-13-1413. Inspections

A. The Department may at any time and without notice inquire into the operation of an ambulance service and may conduct or cause to be conducted, on-site at any hour, inspection in all areas or matters affecting services to the public or involving the regulation of ambulances or ambulance services.

B. If the Department's designated representative(s) determines after an investigation or inspection that a condition or circumstance exists that constitutes a threat to public health, safety, or welfare, the Department's representative may recommend to the Director that he take action to immediately suspend the license or certificate, or both, of the ambulance service.

C. The Director or any designated representative shall not be denied the right to travel upon any ambulance in order to conduct an inspection of any area or matter affecting service to the public or involving the regulation of ambulances or ambulance service when such travel will not directly interfere with services or treatment to a patient.

Historical Note

Adopted as an emergency effective November 29, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Former Section R9-13-

1415 renumbered and amended as permanent rule R9-13-1413 effective March 19, 1984 (Supp. 84-2).

R9-13-1414. Reports

A. Ambulance service dispatch logs
1. Each ambulance service shall maintain and keep current a daily ambulance service dispatch log for all ambulance calls received and shall record all information specified by the Department on a form provided or approved by the Department.
2. The dispatch logs shall be cumulative through each month.
3. On or before the 15th day of each month, the ambulance service shall submit a duplicate of its dispatch logs for the previous month to the Department.

B. Patient encounter records
1. Each ambulance service shall complete and maintain patient encounter records on a form provided or approved by the Department.
2. A copy of each patient encounter record shall be submitted, when requested, by the Department.

C. Financial statements
1. Each ambulance service shall file with the Department no later than 105 days following completion of their annual accounting period financial and operating statements for the preceding accounting period or portion thereof if the ambulance service was not in operation for the full accounting period.
2. The Department reserves the right to audit the books, papers, and financial records of an ambulance service or to request that such review be performed by an independent source at the Department's expense in order to verify the accuracy of any financial and operating statements or related reports or to obtain any required ambulance and ambulance service data.

D. Accidents. A report of any accidents involving an ambulance in the state which results in loss of life or injury to person(s) which requires treatment, property damage in an amount exceeding $500.00, or which renders an ambulance incapable of operating as an ambulance shall be filed with the Department in writing within five days after the occurrence.

Historical Note

Adopted as an emergency effective November 29, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Former Section R9-13-1416 renumbered and amended as permanent rule R9-13-1414 effective March 19, 1984 (Supp. 84-2).

R9-13-1415. Miscellaneous

A. Notice by ambulance service of responsible officer or person.
1. Each ambulance service shall file with the Department a written statement containing the name, addresses (business, residence and post office) and telephone numbers (business and residence) of at least one officer or employee responsible for the general management of its operations at its central operations station and each approved sub-operation station.
2. Each ambulance service shall give notice, by filing a written statement with the Department, of any change in information required herein within five days from the date of any such change.

B. Date of transmittal. If a report, record or remittance required by this Article to be filed with or made to the Department is submitted through the United States mail and is not received by the Department until after the date upon which the report, record or remittance was required to be made, and if the envelope bears a United States Postal Service cancellation mark date on or prior to the date set, the Department, upon receipt thereof, will treat the report, record, or remittance as if it had been received on the required date.

C. Observance of service area.
1. No ambulance service shall regularly provide its service within an area other than the service area identified in its Certificate of Necessity.
2. An ambulance service may not transport a patient from, or treat a patient at, a point outside the service area specified in its Certificate of Necessity except:
   a. In life-threatening circumstances to which it is best able to respond,
   b. If no other approved ambulance service is available for immediate and appropriate response, or
   c. If in accordance with a mutual aid agreement with the ambulance service in the service area affected.

D. Advertisement. No ambulance service shall advertise itself, allow itself to be advertised, or otherwise hold itself out as providing ambulance services of a type or in a service area different than that specifically granted by the Department. All ambulance services shall observe approved service areas in conducting or allowing any form of advertisement for its service(s).

E. Patient pickup location. If an ambulance arrives at a patient pickup location prior to the ambulance that was officially dispatched, or would have been dispatched, the ambulance attendant shall immediately consult the local dispatch system and shall comply with the orders given by the dispatch system.

F. Refusal to transport
1. An ambulance service shall not refuse to transport a patient.
2. An ambulance service shall not divest itself of its services to the public by secret intention to refuse to service certain parties or areas within its service area, or by exercising such action.

G. Obedience to traffic laws, ordinances and regulations. The driver of an ambulance, when responding to an emergency call or while transporting a patient on an emergency basis, shall observe all traffic laws, ordinances and regulations and may exercise those special privileges provided in A.R.S. § 28-624.

H. Mutual aid. Ambulance services may have a written agreement with one or more neighboring ambulance services for coverage during times when its own ambulances are not available for service in its service area. Such agreement shall specify the respective duties and responsibilities of the parties and be filed with the Department and each of the parties. Ambulance services provided outside the service area, but in accordance with a mutual aid agreement on file with the Department will not violate service area limitations.

I. Variances
1. Application for variance. An ambulance service may apply to the Department for a time-limited variance from any of the regulations in this Article. Such a variance may be granted if the applicant specifies alternative practices or measures equivalent or superior to those prescribed in the regulation in question and affirmatively substantiates that:
   a. The rationale for the regulation in question can be met or exceeded by the specified alternative practices or measures.
   b. The application of the regulation would impose an undue burden upon the applicant or ambulance service.
   c. Granting the variance will not adversely affect the public health, safety or welfare.

2. Compliance. Any ambulance service that is granted a time-limited variance shall comply with the alternative practices or measures specified in its successful application for the variance.
3. Renewal, revocation, and reporting.
   a. A time-limited variance will not be renewed or extended.
   b. A variance may be revoked automatically and without formal notice or hearing at any time, if a material change in the circumstances justifying its granting occurs.
   c. Any ambulance service that has been granted a variance shall immediately notify the Department of any such material change in circumstances pertinent to its grant of a variance.

J. Waivers
1. Application for waiver. An ambulance service may apply to the Department for a time-limited waiver from any of the regulations in this Article. Such a waiver will be granted if the applicant affirmatively substantiates that:
   a. The regulation in question does not address a problem of significance to the public in relation to the applicant's ambulance service.
   b. The application of the regulation would impose an undue burden upon the applicant or the ambulance service.
   c. Granting a waiver will not adversely affect the public health, safety or welfare.
2. Renewal, revocation, and reporting
   a. A time-limited waiver may be renewed or extended upon re-application at least 30 days prior to the expiration date.
   b. A waiver may be revoked automatically and without formal notice or hearing at any time, if a material change in the circumstances justifying its granting occurs.
   c. Any ambulance service that has been granted a waiver shall immediately notify the Department of any such material change in circumstances pertinent to its grant of a waiver.

Historical Note

Adopted as an emergency effective November 29, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Former Section R9-13-1417 renumbered and amended as permanent rule R9-13-1415 effective March 19, 1984 (Supp. 84-2). Correction in subsection (C)(2) to insert the word 'not' which was inadvertently omitted (Supp. 94-2).

R9-13-1416. Emergency expired

Historical Note

Adopted as an emergency effective November 29, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Former Section R9-13-1416 renumbered and amended as permanent rule R9-13-1414 effective March 19, 1984 (Supp. 84-2).

R9-13-1417. Emergency expired

Historical Note

Adopted as an emergency effective November 29, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Former Section R9-13-1415 renumbered and amended as permanent rule R9-13-1414 effective March 19, 1984 (Supp. 84-2).

Editor's Note: Article 15 was recodified to 9 A.A.C. 25, Article 8 (Supp. 98-1).

Editor's Note: Former Article 15 contained Sections and Exhibits which were adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 36-2205(C). Exemption from A.R.S. Title 41, Chapter 6 means that the Department of Health Services did not submit these rules to the Governor's Regulatory Review Council for review; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

ARTICLE 15. RECODIFIED

R9-13-1501. Recodified

Historical Note

Adopted effective July 11, 1994; received by the Office of the Secretary of State August 4, 1994, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2005(C) (Supp. 94-3). Former Section R9-13-1501 recodified to A.A.C. R9-25-801 (Supp. 98-1).

R9-13-1502. Recodified

Historical Note

Adopted effective October 12, 1994; received by the Office of the Secretary of State October 24, 1994, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) (Supp. 94-4). Former Section R9-13-1502 recodified to A.A.C. R9-25-802 (Supp. 98-1).

Exhibit 1. Recodified

Historical Note

Adopted effective July 11, 1994; received by the Office of the Secretary of State August 4, 1994, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2005(C) (Supp. 94-3). Former R9-13-1502, Exhibit 1 recodified to A.A.C. R9-25-802, Exhibit 1 (Supp. 98-1).

Exhibit 2. Recodified

Historical Note

Adopted effective July 11, 1994; received by the Office of the Secretary of State August 4, 1994, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2005(C) (Supp. 94-3). Former R9-13-1502, Exhibit 2 recodified to A.A.C. R9-25-802, Exhibit 2 (Supp. 98-1).

Exhibit 3. Recodified

Historical Note

Adopted effective July 11, 1994; received by the Office of the Secretary of State August 4, 1994, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2005(C) (Supp. 94-3). Former R9-13-1502, Exhibit 3 recodified to A.A.C. R9-25-802, Exhibit 3 (Supp. 98-1).

Exhibit 4. Recodified

Historical Note

Adopted effective July 11, 1994; received by the Office of the Secretary of State August 4, 1994, under an exemption from the provisions of the Administrative

Procedure Act pursuant to A.R.S. § 36-2005(C) (Supp. 94-3). Former R9-13-1502, Exhibit 4 recodified to A.A.C. R9-25-802, Exhibit 4 (Supp. 98-1).

R9-13-1503. Recodified

Historical Note

Adopted effective November 27, 1995, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) (Supp. 95-4). Former Section R9-13-1503 recodified to A.A.C. R9-25-803 (Supp. 98-1).

Exhibit 1. Recodified

Historical Note

Adopted effective November 27, 1995, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) (Supp. 95-4). Former R9-13-1503, Exhibit 1 recodified to A.A.C. R9-25-803, Exhibit 1 (Supp. 98-1).

TITLE 9. HEALTH SERVICES

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ARTICLE 6. LICENSING OF ENVIRONMENTAL LABORATORIES

Article 6, consisting of Sections R9-14-601 through R9-14-617 adopted effective December 20, 1991 (Supp. 91-4).

Article 6, consisting of Sections R9-14-601 through R9-14-607 repealed effective December 20, 1991 (Supp. 91-4).

Article 6 consisting of Sections R9-14-601 through R9-14-607 adopted effective August 16, 1985.

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Article 7, consisting of Sections R9-14-701 through R9-14-709, adopted effective December 2, 1993 (Supp. 93-4).

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ARTICLE 1. LICENSING OF CLINICAL LABORATORIES

R9-14-101. Legal authority

The following rules, regulations and standards relating to the licensing of clinical laboratories are adopted pursuant to the authority granted in Arizona Revised Statutes, Title 36, Chapter 4.1, Section 36-136(G)(1).

R9-14-102. Definitions

A. When used in this Article, words defined in A.R.S. § 36-451, shall have the same meaning herein.

B. In this Article, unless the context otherwise requires:

1. "Acting director" means a person who has all of the qualifications required of a clinical laboratory director but who is serving on an interim basis not to exceed 90 days until such time as a permanent director has been employed by the laboratory owner, and is approved by the Department.
2. "Chief" means the Chief of the State Laboratories.
3. "Clinical laboratory personnel" means all persons, other than its director, employed in a clinical laboratory who perform or participate in the performance of laboratory examinations and procedures or who instruct or supervise others in the performance of such examinations and procedures. Clinical laboratory personnel does not include persons employed in a clinical laboratory who engage solely in clerical, secretarial, custodial or similar activities.
4. "License" means the certificate issued by the Department indicating the services for which the laboratory has

requested licensure and has been found qualified to perform.

5. "Programs" or "laboratory programs" include quality control, in-service training of personnel and similar functions.
6. "Services" or "laboratory services" include the activities performed by clinical laboratory personnel in carrying out the specialties and subspecialties which comprise the business or output of the laboratory.
7. "Deputy director" means a person who is designated as the individual responsibility for the overall conduct and operation of a clinical laboratory in the absence of its director.

R9-14-103. License application

A. Any person who desires to operate a clinical laboratory shall apply to the Department for a license on a form provided by the Department. The application shall be prepared and signed by both the owner of the clinical laboratory business and the clinical laboratory director. The application should be submitted to the Chief at least 60 days prior to the planned opening date, or, if an application for relicensure, at least 45 days prior to the expiration date of the existing license.

B. Applications shall be complete and accompanied by the appropriate fee.

C. A license may be obtained for any or all of the following specialties and subspecialties:

1. Clinical chemistry.
2. Hematology.
3. Immunohematology, including the subspecialties of blood grouping and Rh typing, Rh titers and cross matching.
4. Microbiology, including the subspecialties of bacteriology, mycology, mycobacteriology, parasitology and virology.
5. Serology, including the subspecialties of syphilis serology and other serology.
6. Urinalysis.
7. Such other specialties or subspecialties as the Department may approve.

R9-14-104. Fees

The fee for application for license and renewal thereof shall depend upon the number of specialties which a laboratory provides and shall be as follows:

1. For services entirely within one specialty, $25.00 for application for a license and $10.00 for application for renewal.
2. For services within two specialties, $35.00 for application for a license and $15.00 for application for renewal.
3. For services within three specialties, $45.00 for application for a license and $20.00 for application for renewal.
4. For services within four specialties, $55.00 for application for a license and $25.00 for application for renewal.
5. For services within five specialties, $65.00 for application for a license and $30.00 for application for renewal.
6. For services within six or more specialties, $75.00 for application for a license and $40.00 for application for renewal.

Historical Note

Amended effective August 7, 1975 (Supp. 75-1).

R9-14-105. Deputy director

There shall be a deputy director in charge of the laboratory in the absence of its director. He must be capable of performing or supervising the performance of services provided by the laboratory.

R9-14-106. Acting director

A clinical laboratory license shall not be issued unless the applicant laboratory has in its employ a director having the qualifications provided in A.R.S. § 36-468, and who meets the requirements of R9-14-107. The name of the clinical laboratory director shall appear on the face of the license certificate.

1. Where the employment of the clinical laboratory director terminates before his successor has been employed, examined and approved, the owner shall immediately appoint or employ an acting director and request that a temporary license be issued showing the name and title of the acting director. Such temporary license shall expire 90 days after the date of the director's termination, or upon the employment of a new director who meets all of the requirements of the law and these regulations, whichever is earlier.
2. While acting in such capacity, the acting director shall have the same authority, responsibilities and duties as is provided by law and regulations for a clinical laboratory director.

R9-14-107. Examination of a director

A. The examination which may be required of applicants to whom A.R.S. § 36-468, subsections (2) and (3), are applicable, shall be conducted at a time and place designated by the Chief but no less frequently than semiannually. The applicants to be examined shall have first filed a completed application, on the form required by the Department, found to be true and correct and shall be given written notice of the time and place at which the next examination will be given.

B. Examination may be written, oral or practical or any combination thereof. Such examinations shall be designed to reasonably test the applicant's theoretical and practical knowledge of the specialty and subspecialty, including tests and procedures, for which the license is sought. Oral examinations may be recorded for further evaluation.

C. Where written examinations are deemed necessary, the Department may develop its own or use a professional examination service such as the one available from the American Public Health Association.

R9-14-108. Quality control program

A. Each laboratory shall establish and file with the Department a detailed description of his quality control program that is acceptable to the Chief. It is the responsibility of each clinical laboratory director to assure that his laboratory is operated in accordance with its approved quality control program.

B. The quality control program of each laboratory shall be designed to assure the clinical reliability of all laboratory results on a continuous basis. Facilities, equipment and instruments shall have inherent capabilities consistent with the services offered and shall be maintained in good operable condition.

C. The procedures used for the collection of specimens (including, when applicable, patient preparation prior to specimen collection), proper specimen identification, storage, and preservation shall be clearly described in writing. All collection procedures must ensure a satisfactory specimen and those procedures currently used shall be designated, dated, and available in the laboratory.

D. The program shall consist of a periodic inspection for the proper operation of equipment and instruments; a program for validation and recalibration of equipment; a dependable reagent and glassware evaluation system, and a continuous surveillance of results. In each case, appropriate records, showing the date of inspection, validation, or evaluation, and

significant actions taken in response to revealed defects, shall be maintained.

E. Manuals of methods and procedures shall be maintained by the laboratory and shall be conveniently available to clinical laboratory personnel and to representatives of the Department for inspection.

R9-14-109. Sanitation and safety requirements

A. All laboratories shall be maintained and operated in a manner which will prevent undue physical, chemical and biological hazards to its employees or other members of the community. To this end, the following shall be met:

1. There shall be sufficient space, well lighted and convenient to sink, water, gas, suction and electrical outlets to perform the services provided by the laboratory with optimum accuracy and safety.
2. All cultural work and processes involving potential sources of aerosolized mycobacteria or systemic fungi should be performed under a biological safety cabinet that has the capability of sterilizing exhaust air before it is discharged. Cabinets shall exhaust filtered air directly to the outside when a recirculating air-conditioning system is used. If a safety cabinet is not used, the room which is used for processing such materials shall have an exhaust system equipped with high efficiency filters. The exhaust air shall be discharged to the outside when a recirculating air-conditioning system is used. All laboratory procedures which involve liberation of toxic, corrosive and explosive substances shall be performed under a fume hood that has a face velocity of 100 feet per minute and an independent exhaust system.
3. Cylinders of compressed gasses shall be properly secured by restraining chains, brackets or other materials sufficiently strong to support the weight of the cylinder or by the use of a base or stand designed for that purpose.
4. The ventilation system shall provide a sufficient number of air changes to remove all toxic and noxious fumes.
5. There shall be a sufficient number of properly grounded electrical outlets with adequately stabilized voltage to avoid fluctuation. Voltage supplied to the laboratory outlets shall correspond to the specific stationary or portable laboratory equipment to be used.
6. Blood or blood components used for transfusion must be stored in a refrigerator that maintains a temperature uniformly between 2°-6°C. This shall be verified continuously by a recording thermometer which is inspected daily. The proper functioning of the refrigerator must be constantly confirmed by a system of audible and visible alarms, which are either battery operated or powered by a circuit different from that of the refrigerator, and which are monitored at all times. Stored blood shall be inspected daily for evidence of hemolysis and possible bacterial contamination.
7. Drain lines from sinks in which acid wastes may be poured shall be fabricated from an acid-resistant material.
8. Flammable or combustible liquids shall be in containers not larger than one quart or in safety cans or in storage cabinets approved by the Underwriters Laboratory for storage of flammable or combustible liquids.
9. Laboratories performing chemical determinations utilizing corrosive materials or solutions shall have an appropriately-located safety shower.
10. Adequate lighting shall be provided. At least 100 to 200 foot candles should be delivered to the work area at bench top level.
11. Each plumbing fixture shall be provided with air gap or vacuum breaker where necessary to eliminate back siphonage hazards.
12. At least one Underwriters approved fire extinguisher shall be in each laboratory. Such extinguishers shall be inspected at least once a year, and recharged if necessary. Fire protection shall be in accordance with requirements of the local fire department where such departments have established requirements.
13. Each laboratory shall request the local fire department to make an inspection of the laboratory each year before its license renewal date.
14. Flammable liquids requiring refrigeration shall be stored in an Underwriters Laboratory-labeled, explosion-proof refrigerator.
15. Syringes, needles, lancets, or other blood letting devices capable of transmitting infection from one person to another shall not be reused unless they are cleaned and sterilized after first having been wrapped or covered in a manner which will insure that they remain sterile until next use.
16. Diagnostic use of radioactive isotopes shall conform to the Regulations for the Control of Ionizing Radiation, 1967, Arizona Atomic Energy Commission.
17. Cultures and specimens to be discarded, and all other potentially infectious materials, shall be sterilized before disposal by either steam under pressure, dry heat, chemical disinfection, or in an incinerator approved by the air pollution control officer having jurisdiction.
18. All parts of the laboratory premises, furnishings, equipment and materials shall be maintained in a clean and sanitary condition. Particular care shall be taken in areas where infectious materials are handled or where sterile surroundings are necessary for test reliability.
19. Water supply of the laboratory shall be obtained from a system approved by the Department.
20. All sewage and liquid wastes shall be discharged into a municipal sewerage system where such a system is available. Where a municipal sewerage system is not available, sewage and liquid wastes shall be collected, treated and disposed of in a manner approved by the Department.

B. The interpretation of standards set forth in this regulation shall be in accordance with applicable codes and standards adopted by reference in R9-1-412.

R9-14-110. Records, maintenance, availability, retention

Records of observations, where appropriate, shall be made concurrently with the performance of each step in the examination of specimens. The actual results of all control procedures shall be recorded. Records shall be initialed or signed by the individual performing the examination. Such records as well as duplicate copies of laboratory reports shall be retained for a period of at least one year after the date the results are reported except as otherwise prescribed by law (copies of premarital serology results must be retained for five years) and shall be made available for inspection by representatives of the Department.

R9-14-111. Personnel records

Personnel records shall be maintained on a current basis. They shall include a complete resume of each employee's training, experience, duties, and date or dates of employment. Attendance records shall be maintained for each employee for a period of one year.

R9-14-112. Records of specimens examined

Records for each specimen examined shall be maintained. They shall contain the following information:

1. The laboratory number or other identification.

2. The name and other identification of the person from whom the specimen was taken, if available.
3. The name of the licensed physician or other person or laboratory who or which submitted the specimen.
4. The date the specimen was collected by the physician or other authorized person.
5. The date the specimen was received in the laboratory.
6. The condition of unsatisfactory specimens and packages, when received, e.g., broken, leaked, hemolyzed, or turbid.
7. Examination requested and result in units of measurement where applicable.
8. Where requested or indicated the normal values for the method used.
9. Initials or signature of the individual conducting examination.

R9-14-113. Reports of certain contagious diseases

The clinical laboratory director shall report to the Department findings or evidence suggestive of syphilis or tuberculosis in accordance with the provisions of R9-6-311, Reporting of Certain Contagious Diseases by Clinical Laboratories.

R9-14-114. Proficiency testing procedures

A. Each laboratory shall participate successfully in a proficiency testing program provided by the American Association of Bioanalysts or the College of American Pathologists for each specialty and subspecialty for which a license is issued except in those specialties and subspecialties for which the Department provides a proficiency testing program. Records of such testing shall be kept for two years and shall be made available for examination on request by representatives of the Department. Laboratory personnel shall enter the date and time of receipt of samples, results, and such other information as may be required on forms provided by the proficiency testing service.

B. Each laboratory shall also participate successfully in a Department-operated proficiency testing program. Such testing may be carried out during on-site inspections or by submittal of specimens by mail. Regularly assigned personnel must examine samples using the laboratory's routine methods. The laboratory shall be tested only in specialties or subspecialties for which a license application, original or renewal, has been filed with the Chief or for which the Department has issued a license. The samples to be tested may be provided prior to, during, or subsequent to, inspections. The time allowed for testing will be the time required, as determined by the Chief under conditions of normal laboratory operation. Laboratory personnel shall enter the date and time of receipt of samples, results of tests, and such other information as the Chief may require, on forms provided or required by the Department.

R9-14-115. Standards of performance

A. A degree of sensitivity, specificity, reproducibility and precision satisfactory to the Department shall be demonstrated in proficiency tests.

B. The required level of performance as measured by proficiency testing shall be consistent with the nature and extent of services offered by the laboratory in reporting values of medical significance.

R9-14-116. Repealed

Historical Note

Adopted effective May 24, 1976 (Supp. 76-3. Repealed effective August 15, 1989 (Supp. 89-3).

ARTICLE 2. PREMARITAL AND PRENATAL SEROLOGY TESTS FOR SYPHILIS

R9-14-201. Reserved

R9-14-202. Reserved

R9-14-203. Reserved

R9-14-204. Reserved

R9-14-205. Reserved

R9-14-206. Reserved

R9-14-207. Reserved

R9-14-208. Reserved

R9-14-209. Reserved

R9-14-210. Reserved

R9-14-211. Certificate of approval, state licensed laboratories

All laboratories operated within and as a part of a hospital or licensed by the Department pursuant to Article 1 of this Chapter for the performance of syphilis serology are "approved laboratories" for premarital and prenatal examinations pursuant to A.R.S. §§ 25-103.05, 25-103.06 and 36-693. Any other laboratory, exempted from the application of Chapter 4.1, Title 36, for which such approval is desired may apply to the Department's Chief of State Laboratories for a Certificate of Approval. Such certificates will be granted to applicants in accordance with the procedures and criteria provided in this Article.

R9-14-212. Application

A. All laboratories exempted from the application of Title 36, Chapter 4.1, for which Department approval to perform premarital or prenatal serology tests for syphilis is required shall qualify for and hold a current and valid Certificate of Approval.

B. Application for a Certificate of Approval shall be made to the Department on a form provided by the Department. The application shall be signed by both the laboratory director and the owner of the laboratory business or, if operated by a governmental agency, by the chief administrative officer of the agency. The application should be submitted at least 30 days prior to the date issuance is desired.

R9-14-213. Provisional approval

Laboratories applying for approval for the first time will be given provisional status after an on-site visit has been conducted to observe the competency of the laboratory staff and the adequacy of laboratory equipment, reagents, and performance of the procedure for which the laboratory is seeking approval. If laboratory's performance is appraised as satisfactory, provisional approval will be issued for a period of time not to exceed six months. A certificate will be issued to the laboratory upon expiration of the provisional certificate only if the applicant has fully demonstrated its capability to perform syphilis serology tests.

R9-14-214. Approved serological tests

For the purposes of performing premarital serology tests for syphilis pursuant to A.R.S. §§ 25-103.05 and 25-103.06 or prenatal serology tests for syphilis pursuant to A.R.S. § 36-693, only those tests contained in the 1969 edition of the "Manual of Tests for Syphilis", P.H.S. Publication 411, are approved, except that the U.S.R.,Unheated Serum Reagin, test is not an approved test. Standards for procedures and equipment used in serological tests for syphilis shall be as provided in the "Manual of Tests for Syphilis".

R9-14-215. Proficiency testing

A. All "approved laboratories" shall participate successfully in a Department-operated proficiency testing program, as directed by the Chief of State Laboratories.

B. Such testing may be carried out during on-site inspections or by submittal of specimens by mail for examination. Regularly-assigned personnel must examine samples using the laboratory's routine method. The samples to be tested may be provided prior to, during, or subsequent to, inspections. The time allowed for testing will be the time required, as determined by the Chief of State Laboratories under conditions of normal laboratory operation. Laboratory personnel shall enter the date and time of receipt of samples, results of tests, and such other information as the Chief of State Laboratories may require, on forms provided or required by the Department.

C. A degree of sensitivity, specificity, reproducibility and precision satisfactory to the Department shall be demonstrated in proficiency tests.

ARTICLE 3. LABORATORY TESTS

R9-14-301. Fees

Except as provided in R9-14-302, the amount of the fees charged for laboratory tests performed by the State Laboratory shall be in accordance with the following fee schedule:

1.	Clinical Bacteriology	
	a. TB Smear, Culture and Drug Susceptibility	$7.00
	b. Mycology (systemic fungi/dermatophyte)	5.00
	c. Bacterial Isolation and Identification	7.00
2.	Clinical Immunology	
	a. TORCH (toxoplasmosis, rubella, CMV, Herpes, VDRL)	13.00
	b. Syphilis	
	i. VDRL (no charge for prenatal specimens)	2.25
	ii.. FTA	3.00
	c. Fungal	
	i. C. immitis C.F.	2.50
	ii. C. immitis Pptn	2.50
	iii. Histoplasmosis	2.50
	d. Viral	
	i. CNS	11.50
	ii. Exantham	11.50
	iii. Respiratory	11.50
	iv. Rickettsial	11.50
	v. Enterovirus	11.50
	vi. Rubella	2.75
	e. Parasitic	
	f. Toxoplasmosis	2.50
3.	Clinical Virology (Isolations and Identification)	20.00
4.	Environmental Microbiology (Water)	
	a. Total Coliform (membrane filter)	1.25
	b. Coliform (multiple tube)	1.25
5.	Environmental Chemistry (Water)	
	a. Routine (total iron, manganese, sodium, chloride, sulfate, fluoride, nitrate, total dissolved solids, hardness, alkalinity, calcium, magnesium, copper, zinc, pH, arsenic, silver, cadmium lead, selenium and mercury)	28.00
	b. Trace Metals (arsenic, silver, cadmium, lead, selenium and mercury) each	1.00

Historical Note

Adopted effective September 29, 1976 (Supp. 76-4).

R9-14-302. Exceptions

A. Each county, city, town, public school, public school district, or any political subdivision thereof, is exempt from payment of fees listed in R9-14-301.

B. The following specimens and services are exempt from payment of fees listed in R9-14-301:

1. Reference diagnostic specimens (serum or culture) which have undergone some processing in a hospital or an independent or public health laboratory and are being submitted for confirmation or further identification.
2. Specimens requested by county or state public health officials to aid in the investigation of infectious disease outbreaks or other public health problems.
3. Specimens submitted for rabies examination.
4. Services supported by special federal grant to study infectious disease or environmental contamination.

Historical Note

Adopted effective September 29, 1976 (Supp. 76-4).

ARTICLE 4. DETERMINATION OF ALCOHOL CONCENTRATION

R9-14-401. Definitions

In this Article, unless the context otherwise requires:

1. "Alcohol concentration" or "AC" means grams of alcohol per 100 milliliters of blood or grams of alcohol per 210 liters of breath.
2. "Analyst" means a person who has an analyst permit to use approved methods to make a determination of alcohol concentration from a specimen of blood, breath, breath alcohol, urine or other bodily substances.
3. "Analyst permit" means a certificate issued by the Department indicating the permit holder has been found qualified to utilize approved methods in the determination of alcohol concentration.
4. "Analytical procedure" means a series of operations utilized by an analyst when employing an approved method in the determination of alcohol concentration.
5. "Calibration solutions" means solutions with a known alcohol concentration used to determine the accuracy of breath testing devices.
6. "Class I operator permit" means a certificate issued by the Department indicating the permit holder has been determined to be qualified to utilize an approved breath testing device or collection device or both.
7. "Class II operator permit" means a certificate issued by the Department indicating the permit holder has been determined to be qualified as a quality assurance specialist.
8. "Deprivation period" means a 15-minute period immediately prior to a quantitative duplicate breath test during which period the subject has not ingested any alcoholic beverages or other fluids, vomited, eaten, smoked or placed any foreign object in the mouth.
9. "Determination" means the analysis of a specimen of blood, breath, breath-alcohol, urine or other bodily substance and expressing the results of such analysis or test in terms of alcohol concentration.
10. "Device" means a breath testing or collection instrument intended for use by an operator for the purpose of obtaining a determination of alcohol concentration from a specimen of breath, or collecting a sample from breath for

subsequent determination of the alcohol concentration by an analyst.

11. "Duplicate test" means two consecutive breath tests conducted after a deprivation period.
12. "Instructor" means a person approved by the Department to offer training in breath testing to prospective operators of approved breath testing or collection devices.
13. "Method" means the scientific process utilized by an analyst or the scientific process utilized by a device to make an alcohol concentration determination.
14. "Operator" means a person who has been issued an operator permit and operates a breath testing or collection device for the purpose of obtaining a determination of alcohol concentration from a specimen of breath.
15. "Preliminary breath test" means a pre-arrest breath test.
16. "Preliminary breath tester" or "PBT" means any approved breath testing instrument used prior to an arrest for the purpose of obtaining a determination of alcohol concentration from a specimen of breath.
17. "Procedure" means a series of operations utilized by the operator when employing an approved device in the determination of alcohol concentration or in the collection of breath alcohol specimens.
18. "Quality assurance specialist" means a person who has been issued a Class II operator permit from the Department to perform quality assurance testing to ensure the proper and accurate operation of a specific breath testing device or collection device or both.

Historical Note

Adopted prior to codification November 1974. Amended as an emergency effective July 19, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-4). Amended as a permanent rule effective October 25, 1982; text of the amended rule identical to the emergency (Supp. 82-5). Former Section R9-14-411 renumbered without change as Section R9-14-401 effective March 3, 1987 (Supp. 87-1). Former Section R9-14-401 repealed, new Section R9-14-401 renumbered from R9-14-402 and amended effective August 27, 1992 (Supp. 92-3). Amended effective February 28, 1994 (Supp. 94-1).

R9-14-402. Analyst Methods; Approval of Additional Methods

A. An analyst shall use one of the following methods to analyze blood, breath, breath alcohol, urine specimens, or other bodily substances to determine a person's alcohol concentration:
1. Gas chromatography determinations, or
2. Enzymatic determinations with qualitative screening.

B. An applicant for an analyst permit may submit, with the permit application, a request that the Director approve additional methods.

C. For a method to be approved by the Director, its accuracy and reproducibility shall comply with the following standards:
1. The test results of samples with a known alcohol concentration shall agree with the established value within the limits of +0.01 grams per 100 milliliters of blood or ±10%, whichever is greater.
2. The accuracy and precision shall be determined on the basis of ten measurements at four alcohol concentrations between 0.050 and 0.250 grams per 100 milliliters of blood.

Historical Note

Adopted prior to codification November 1974. Amended as an emergency effective July 19, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-4). Amended as a permanent rule effective October 25, 1982; text of the amended rule similar to the emergency (Supp. 82-5). Amended Paragraph (11) as an emergency effective 12:00 midnight, May 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended Paragraph (11) as a permanent rule effective August 27, 1984 (Supp. 84-4). Former Section R9-14-412 renumbered without change as Section R9-14-402 effective March 3, 1987 (Supp. 87-1). Former Section R9-14-402 renumbered to R9-14-401, new Section R9-14-402 renumbered from R9-14-403 and amended effective August 27, 1992 (Supp. 92-3). Amended effective February 28, 1994 (Supp. 94-1).

R9-14-403. Breath-testing and Collection Devices

A. Devices used to determine alcohol concentration from breath or to collect a sample from breath for subsequent determination by an analyst may be approved for use, by the Director, after the Department successfully tests a typical model of the device for compliance with the standards in subsections (B) and (C).

B. Devices utilized to determine alcohol concentration from a sample of breath shall meet the following standards of performance:
1. Breath specimens tested shall be alveolar in composition.
2. Breath-testing devices shall be capable of analysis of a solution of known alcohol concentration with an accuracy limit of a systematic error of no more than ±0.005 grams per 210 liters of breath or ±5%, whichever is greater, and a precision limit of an average standard deviation of no more than .0042 grams per 210 liters of breath. The accuracy and precision of the devices being evaluated shall be determined on the basis of 10 consecutive measurements at 4 alcohol vapor concentrations which are between 0.050 and 0.250 grams per 210 liters of breath.
3. The device shall be capable of testing a breath sample which results in alcohol concentrations of less than .01 grams per 210 liters of breath when alcohol-free subjects are tested.

C. Devices utilized to collect a sample from breath for subsequent determination of alcohol concentration by an analyst shall meet the following standards of performance:
1. The device shall be capable of reproducing the known alcohol concentration of a reference sample with an accuracy limit of a systematic error of no more than ±.005 grams per 210 liters of breath or ±5%, whichever is greater, and a precision limit of an average standard deviation of no more than .0042 grams per 210 liters of breath. The accuracy and precision of the devices being evaluated shall be determined on the basis of 10 consecutive measurements at 4 alcohol vapor concentrations which are between 0.050 and 0.250 grams per 210 liters of breath.
2. The device shall be capable of collecting a sample from breath which results in an alcohol concentration of less than 0.01 grams per 210 liters of breath when alcohol-free subjects are tested.

D. Collection devices approved by the Director may be used in conjunction with any compatible approved breath-testing device.

E. The Department, upon specific findings that a device, method or procedure is not accurate, is unreliable, or is not an acceptable analysis or test for determining alcohol concentration or of collecting samples or that its use has been discontinued in the state shall disapprove further use of the device, method, or procedure.

F. The methods approved by the Director for use by breath-testing devices to determine alcohol concentration are infrared absorbance, spectrophotometry, gas chromatography, and specific fuel cell detectors.

G. The following quantitative breath-testing and collection devices are approved by the Director:

Model	Manufacturer
Breathalyzer 900/900A	Smith and Wesson Co.
Alco-Sensor III	Intoximeters, Inc.
Intoxilyzer Models 4011A Modified and 4011AS Modified with or without Beam Attenuator	CMI, Inc./Federal Signal
Intoxilyzer Models 4011A Modified and 4011AS Modified with Sample Preservation Modification with or without Beam Attenuator	CMI, Inc./Federal Signal
Intoxilyzer Model 5000	CMI, Inc./Federal Signal
Intoxilyzer Model 5000 with or without Vapor Recirculation and with or without Keyboard	CMI, Inc.
Intoximeter Model 3000	Intoximeters, Inc.
Mark IV GCI	Intoximeters, Inc.
GCI Field Collection Unit	Intoximeters, Inc.
PST-10 Silica Gel Tube (also known as SM-10 Silica Gel Tube)	Luckey Laboratories, Inc./ U.S. Alcohol Testing of America, Inc.
RBT IV (Alco Sensor IV with a RBT IV printer microprocessor)	Intoximeters, Inc.
Toxtrap Silica Gel Tube	Toxtrap, Inc./ Federal Signal

H. Products included on the National Highway Traffic Safety Administration's Conforming Products List of Evidential Breath Measurement Devices set forth in 57 FR 8376, March 9, 1992, and no further amendments, incorporated by reference and on file with the Office of the Secretary of State, are approved by the Director as preliminary breath testers to determine alcohol concentration.

I. Except when a device is used as a PBT, an operator's permit and approved operational procedure are required for the operation of quantitative breath-testing devices listed in subsection (G).

J. Quantitative breath-testing devices listed in subsection (G) may be used to administer preliminary breath tests.

K. In addition to the quantitative breath testing and collection devices approved in subsection (G), the Director shall approve, in writing, a device and the related quality assurance and operator procedure forms after the device is successfully tested for compliance with the standards in subsections (B) and (C) for use prior to and pending such device being added to subsection (G). The approval shall expire 2 years after its effective date unless subsection (G) is amended to include the approved device.

Historical Note

Adopted prior to codification November 1974. Amended as an emergency effective July 19, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-4). Amended as a permanent rule effective October 25, 1982; text of the amended rule similar to the emergency (Supp. 82-5). Former Section R9-14-413 renumbered without change as Section R9-14-403 effective March 3, 1987 (Supp. 87-1). Former Section R9-14-403 renumbered to R9-14-402, new Section R9-14-403 renumbered from R9-14-404 and amended effective August 27, 1992 (Supp. 92-3). Amended by emergency action effective June 1, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-2). Amended again by emergency action effective September 16, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Amended again by emergency action effective December 13, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-4). Emergency amendments permanently adopted effective February 28, 1994 (Supp. 94-1). Amended effective February 12, 1996 (Supp. 96-1).

R9-14-404. Testing Procedures

A. Law enforcement agencies or individuals acting independently of such agencies who conduct alcohol concentration determinations by means of breath-testing devices shall implement a quality assurance program conducted by a quality assurance specialist. This quality assurance program shall include:

1. Criteria for insuring the proper operation of devices by testing device controls and indicators to ensure that they are functioning as required by the Department quality assurance procedure for the devices. The examinations shall be performed and recorded within 90 days of each other following the appropriate Department quality assurance procedure set forth in Exhibits F, H, J, M, Q, QQ, T, V, and Z or as approved by the Director in accordance with R9-14-403(K).
2. Calibration checks of breath-testing devices which shall be performed and recorded in accordance with the requirements of the appropriate Department quality assurance procedure set forth in Exhibits F, J, L, P, PP, S, V, and Y or as approved by the Director in accordance with R9-14-403(K).
3. Calibration checks of breath testing devices which shall be performed within 31 days of each other. These checks shall indicate that the device is capable of determining the value of a known alcohol reference standard with an acceptable accuracy limit of ±0.01 grams per 210 liters of breath or ±10%, whichever is greater. A device performing outside this accuracy limit shall be removed from service until repair or maintenance is performed and the device operates within the accuracy limits.
4. Evaluation of collection devices used to provide preserved breath alcohol samples. Collection device samples shall be collected within 90 days of each other and analyzed within 60 days of collection to ensure they are reasonably reliable.
5. Standards for preparation of calibration solutions which shall be prepared using 1 or more of the following techniques. In addition, calibration solutions made by techniques (a) or (b) below shall be verified by titration or gas chromatography:
   a. Volumetric dilution of an absolute ethyl alcohol sample,
   b. Gravimetric dilution of an absolute ethyl alcohol sample,
   c. Volumetric dilution of a known ethyl alcohol sample,
   d. Gravimetric dilution of a known ethyl alcohol sample, or
   e. Commercially produced ethyl alcohol standard.
6. Records of quality assurance testing, calibration checks, device adjustments, and any maintenance for each device in use.

B. Operator permit holders shall utilize the operator procedure approved by the Department for the device being operated in performing tests and collecting samples for the determination of alcohol concentration, as contained in Exhibits E, EE, G, I, II, K, KK, N, NN, O, OO, OOO, R, RR, U, UU, W, WW, WWW, and X or as approved by the Director in accordance with R9-14-403(K).

C. Duplicate quantitative breath tests shall be administered at intervals of not less than 5 minutes nor more than 10 minutes. The results of both tests shall be within .020 alcohol concentration of each other. If the 2nd test is not within .020 alcohol concentration of the 1st test, additional tests shall be administered until the results of 2 consecutive tests are within .020 alcohol concentration.

Historical Note

Adopted prior to codification November 1974. Amended as an emergency effective July 19, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-4). Amended as a permanent rule effective October 25, 1982; text of the amended rule similar to the emergency (Supp. 82-5). Amended as an emergency effective 12:00 midnight, May 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as a permanent rule effective August 27, 1984 (Supp. 84-4). Former Section R9-14-414 renumbered and amended as Section R9-14-404 effective March 3, 1987 (Supp. 87-1). Former Section R9-14-404 renumbered to R9-14-403, new Section R9-14-404 renumbered from R9-14-405 and amended effective August 27, 1992 (Supp. 92-3). Amended effective February 28, 1994 (Supp. 94-1). Amended effective February 12, 1996 (Supp. 96-1).

R9-14-405. Permits

A. The Department shall issue two categories of operator permits.
1. Class I operator permits shall be issued to applicants who qualify under R9-14-406(A). The permit authorizes operation of the device specified on the permit and shall be valid until revoked. The holder of a Class I operator permit is approved to use all procedures for the specific device.
2. Class II operator permits shall be issued to qualified applicants who hold a Class I operator permit and who qualify as a quality assurance specialist under R9-14-406(E). The Class II operator permit authorizes the quality assurance specialist to perform testing to assure the proper and accurate operation of a specific breath testing or collection device. A Class II operator permit shall be valid until revoked.

B. Law enforcement agencies shall supply the Department, upon request, with a list of operator permit holders and shall update the list as required by the Department but no more frequently than annually.

C. Operators who were issued permits by the Department prior to July 24, 1982, shall be considered certified operators as long as their permit has not been suspended or revoked. Operators previously issued quality assurance specialist permits shall assume the title of Class II operator on the effective date of these rules. The Department shall issue a Class II operator permit to all persons who were quality assurance specialists prior to the effective date of these rules. This change in title has no effect on the authorized scope of authority of those individuals previously known as quality assurance specialists.

D. The Department shall issue analyst permits to qualified applicants, in accordance with R9-14-406(B), who have satisfactorily demonstrated, through proficiency testing as specified in R9-14-408(B), their knowledge and proficiency in conducting an alcohol concentration determination by one or more of the methods listed in R9-14-402. The analyst permit shall:
1. State the method of alcohol concentration determination the permit holder is authorized to utilize and the type of specimen the permit holder is approved to analyze, whether blood, breath, breath alcohol, urine and/or other bodily substances; and
2. Be valid for a period of one year.

E. The holder of an analyst permit shall employ, in testing for alcohol concentration in matters arising under A.R.S. Title 28, Chapter 6, Article 5, the same analytical procedures as those employed by the analyst for proficiency testing.

Historical Note

Adopted prior to codification November 1974. Amended as an emergency effective July 19, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-4). Amended as a permanent rule effective October 25, 1982; text of the amended rule similar to the emergency (Supp. 82-5). Amended as an emergency effective 12:00 midnight, May 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as a permanent rule effective August 27, 1984 (Supp. 84-4). Former Section R9-14-415 renumbered and amended as Section R9-14-405, Exhibits E through U amended, and Exhibits V through X adopted effective March 3, 1987 (Supp. 87-1). Former Section R9-14-405 renumbered to R9-14-404 and Exhibits E through X moved to end of Article, new Section R9-14-405 renumbered from R9-14-406 and amended effective August 27, 1992 (Supp. 92-3). Amended effective February 28, 1994 (Supp. 94-1).

R9-14-406. Qualifications

A. To qualify for a Class I operator permit, a person shall:
1. Be employed by a law enforcement agency or by a laboratory which has access to a breath testing or collection device for the person's use as set forth in R9-14-403; and
2. Complete a course approved by the Department, with a score of 70% or better, in the determination of alcohol concentration. The Department shall approve courses taught by an approved breath testing instructor if they contain the following:
   a. Instruction on the effects of alcohol on the human body;
   b. Instruction on and demonstration of the operational principles of the selected testing or collection method, which shall include a functional description and detailed operational description of the method;
   c. Instruction on the legal aspects of breath tests in general and of the particular method to be employed;
   d. Applicant participation with appropriate breath testing device utilizing reference standards, testing of subjects, or other methods which will indicate the actual response of the device; and
   e. Written and practical examination of the applicant for the purpose of determining the person's understanding and proficiency.

B. To qualify for an analyst permit, a person shall be a medical technologist or hold a degree from a college or university accredited by a regional accrediting body recognized by the United States Department of Education with 15 or more credits of chemistry, including 3 or more credits of organic chemistry.

C. To qualify as a breath testing instructor, a person shall hold a Class I and a Class II operator permit on the device for which instruction is given. In addition, except as provided in subsec-

tion (D), all applicants shall comply with one of the following requirements:

1. Complete an instructor training course approved by the Department, with a score of 75% or better on a comprehensive examination. The Department shall approve instructor training courses if they are taught by an approved breath testing instructor and contain the following:
   a. Review of the theory of breath testing and the operation of the particular testing device; and
   b. Procedures for testing instrument functions, calibration testing and the operational controls in accordance with quality assurance procedures approved by the Department.
2. Receive a score of 75% or better on a comprehensive examination administered by the Department.

D. If a breath testing device is newly approved and no Class I and Class II operator permits have been issued for the device, a person may qualify to be a breath testing instructor and a Class I and II operator for such device by complying with the following requirements:

1. Complete an instructor training course conducted by the Department, with a score of 75% or better on a comprehensive examination administered by the Department. The instructor training course shall contain the following:
   a. Review of the theory of breath testing and the operation of the particular testing device; and
   b. Procedures for testing instrument functions, calibration testing, and the operational controls in accordance with quality assurance procedures approved by the Department.
2. Receive a score of 75% or better on a comprehensive examination administered by the Department.

E. To qualify for a Class II operator permit, a person shall possess a Class I operator permit to operate the approved breath testing device and shall comply with one of the following:

1. Complete a course of training approved by the Department, with a score of 75% or better. The Department shall approve courses taught by an approved breath testing instructor if they contain the following:
   a. Review of the theory of breath testing and the operation of the particular testing device; and
   b. Procedures for testing instrument functions and the operational controls in accordance with quality assurance procedures approved by the Department; and
   c. Calibration testing procedures approved by the Department.
2. Pass a proficiency test, administered by the Department or an approved instructor, with a score of 75% or better which demonstrates that the requirements equivalent to those contained in paragraph (1) have been met through training, knowledge and experience.

Historical Note

Adopted prior to codification November 1974. Amended as an emergency effective July 19, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-4). Amended as a permanent rule effective October 25, 1982; text of the amended rule similar to the emergency (Supp. 82-5). Former Section R9-14-416 renumbered and amended as R9-14-406 effective March 3, 1987 (Supp. 87-1). Former Section R9-14-406 renumbered to R9-14-405, new Section R9-14-406 renumbered from R9-14-407 and amended effective August 27, 1992 (Supp. 92-3). Amended effective February 28, 1994 (Supp. 94-1).

R9-14-407. Application Processes

A. An applicant for an initial analyst permit or the renewal of an existing analyst permit shall use the form shown as Exhibit A to apply. The applicant shall complete the application, providing the applicant's qualifications for the permit, and submit it to the Department. An application for renewal of an analyst permit shall be submitted no later than 30 days prior to the date the current permit expires.

B. Application for a Class I operator permit shall be made on a form shown as Exhibit B. The application shall be submitted providing the applicant's qualifications for the permit.

C. Application for a breath testing instructor approval shall be made on a form shown as Exhibit C. The application shall be submitted providing the applicant's qualifications for approval.

D. Application for a Class II operator permit shall be made on a form shown as Exhibit D. The application shall be submitted providing the applicant's qualifications for the permit.

Historical Note

Adopted prior to codification November 1974. Amended as an emergency effective July 19, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-4). Correction to emergency adoption, Subsection (C) should include Paragraph (4) as follows: "Receive a score of 70% or better on an examination administered by the Department". Amended as a permanent rule effective October 25, 1982; text of the amended rule similar to the emergency (Supp. 82-5). Former Section R9-14-417 renumbered and amended as Section R9-14-407 effective March 3, 1987 (Supp. 87-1). Former Section R9-14-407 renumbered to R9-14-406, new Section R9-14-407 renumbered from R9-14-408 and amended effective August 27, 1992 (Supp. 92-3). Amended effective February 28, 1994 (Supp. 94-1).

R9-14-408. Examination and Quality Assurance Requirements for Analysts

A. The Department shall require an analyst permit applicant to successfully demonstrate the applicant's proficiency in making determinations from test specimens in accordance with subsection (B). The applicant shall be examined only on the methods which relate to the type of determination for which the applicant desires a permit.

B. An applicant shall, before receiving an initial analyst permit or renewal of an existing analyst permit, participate in and successfully complete proficiency testing administered by the Department. Successful analysis of samples shall include testing suitable reference standards or control samples with a known alcohol concentration in the range of 0.00 to 0.30 grams per 100 milliliters of blood, the results of which shall agree with the established value within the limits of ±0.01 grams per 100 milliliters of blood or ±10%, whichever is greater. Proficiency testing shall be administered by the Department as follows:

1. An applicant shall correctly analyze all proficiency samples in the set provided by the Department.
2. When returning the results of analyses to the Department, the applicant shall attach an affidavit attesting that the applicant analyzed the proficiency samples without help or input from any other person.
3. An applicant failing to correctly analyze all proficiency samples in the set will be provided an opportunity to successfully analyze a second set of samples.
4. The application of an applicant who declines or fails to correctly analyze the second set of proficiency samples shall be denied and a permit shall not be issued.

5. An applicant who fails to successfully analyze the second set of proficiency samples and whose application is denied may reapply for an analyst's permit in three months, after the applicant revises the analytical procedure used in order to improve the accuracy of test results.

C. A quality assurance program shall be implemented and maintained by analysts who conduct alcohol concentration determinations. This program shall be designed to ensure the validity of test results by providing for the following standards:
1. Chain of custody,
2. Quality control,
3. Analytical procedures,
4. Documentation of test results, and
5. Participation in proficiency testing.

Historical Note

Adopted prior to codification November 1974. Amended as an emergency effective July 19, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-4). Amended as a permanent rule effective October 25, 1982; text of the amended rule similar to the emergency. Exhibits A and B initially adopted as part of the emergency amendment now adopted as part of the permanent rule (Supp. 82-5). Amended as an emergency effective 12:00 midnight, May 20, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as a permanent rule effective August 27, 1984. Exhibits C and D initially adopted as part of the emergency (Supp. 84-4). Editorial correction, Supp. 84-3, should read Amended as an emergency effective 12:00 midnight, May 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Former Section R9-14-418 renumbered without change as R9-14-408, Exhibits A through D amended effective March 3, 1987 (Supp. 87-1). Former Section R9-14-408 renumbered to R9-14-407 and Exhibits A through D moved to end of Article, new Section R9-14-408 renumbered from R9-14-409 and amended effective August 27, 1992 (Supp. 92-3). Amended effective February 28, 1994 (Supp. 94-1).

R9-14-409. Revocation or Suspension of Permits; Appeals

A. The Department may suspend or revoke a permit upon any of the following grounds:
1. A false statement on the permit holder's application;
2. The neglect or refusal to examine and report the results of sample specimens given the analyst permit holder for proficiency testing purposes;
3. The failure by an analyst to maintain quality control over equipment or reagents needed to assure accurate results;
4. Failure to obtain results on proficiency test samples as indicated in R9-14-408(B);
5. The failure to operate a breath testing or collection device according to approved procedures or the failure to analyze blood, breath, breath alcohol, urine or other bodily substances according to approved methods; or
6. The failure by a permit holder to maintain documentation required by this Article or to make it available to Departmental representatives for inspection for purposes of administering this Article.

B. When a permit has been suspended or revoked in one or more of the approved methods and there remains one or more methods for which the permittee is approved and which are not affected by the revocation or suspension, the permit holder shall return the suspended or revoked permit to the Department which shall issue a replacement permit. The replacement permit will show only those approved methods or devices unaffected by the event leading to the suspension or revocation.

C. The provisions of A.R.S. Title 41, Chapter 6, Article 6 and the rules of practice and procedure in A.A.C. Title 9, Chapter 1, Article 1 are applicable to denials, revocations, suspensions and administrative appeals.

Historical Note

Adopted prior to codification November 1974. Amended as an emergency effective July 19, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-4). Amended as a permanent rule effective October 25, 1982; text of the amended rule similar to the emergency (Supp. 82-5). Section R9-14-419 renumbered without change as Section R9-14-409 effective March 3, 1987 (Supp. 87-1). Former Section R9-14-409 renumbered to R9-14-408, new Section R9-14-409 renumbered from R9-14-411 and amended effective August 27, 1992 (Supp. 92-3).

R9-14-410. Repealed

Historical Note

Adopted prior to codification November 1974. Amended as an emergency effective July 19, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-4). Amended as a permanent rule effective October 25, 1982; text of the amended rule identical to the emergency (Supp. 82-5). Former Section R9-14-420 renumbered without change as Section R9-14-410 effective March 3, 1987 (Supp. 87-1). Section R9-14-410 repealed effective August 27, 1992 (Supp. 92-3).

R9-14-411. Renumbered

Historical Note

Adopted prior to codification November 1974. Amended as an emergency effective July 19, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-4). Amended as a permanent rule effective October 25, 1982; text of the amended rule similar to the emergency (Supp. 82-5). Former Section R9-14-421 renumbered and amended as Section R9-14-411 effective March 3, 1987 (Supp. 87-1). Former Section R9-14-411 renumbered to R9-14-409 effective August 27, 1992 (Supp. 92-3).

R9-14-412. Repealed

Historical Note

Adopted as an emergency effective 12:00 midnight, May 20, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Adopted as a permanent rule effective August 27, 1984 (Supp. 84-4). Editorial correction, Supp. 84-3, should read Amended as an emergency effective 12:00 midnight, May 29, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-6). Former Section R9-14-422 renumbered and amended as Section R9-14-412 effective March 3, 1987 (Supp. 87-1). Section R9-14-412 repealed effective August 27, 1992 (Supp. 92-3).

EXHIBIT A
APPLICATION FOR ANALYST PERMIT

ARIZONA DEPARTMENT OF HEALTH SERVICES
Division of State Laboratory Services
1520 West Adams Street
Phoenix, Arizona 85007
(602) 542-1188

Application for analyst permit to perform analysis of a person's blood, breath, breath-alcohol, urine, or other bodily substances for alcohol.
TO BE COMPLETED BY APPLICANT PLEASE PRINT CLEARLY
(ALL ITEMS MUST BE COMPLETED OR APPLICATION WILL NOT BE ACCEPTED)

DO YOU HAVE AN ANALYST PERMIT? YES _____ PERMIT NUMBER _____
NO _____

1. Name: _____
(last) (first) (middle) maiden)
2. Date of Birth _____
3. Employer's Name: _____
_____
address
4. Education: (If not a high school graduate, have you successfully passed the "General Education Development" test?)
Yes _____ No _____ Date _____
_____
high school attended (city & state) (year graduated)
_____
college attended (city & state) (year graduated)(degree)

Check the following which apply:
1. A medical technologist qualified by: _____ _____
2. Holder of a degree from an accredited college or university with 15 or more credits of college chemistry with at least 3 credits in organic chemistry. _____

Check the analytical method(s) for which you wish to obtain a permit:
Gas Chromatography _____
Enzymatic Analysis with qualitative screening _____
Other: _____
_____

I hereby certify that the information submitted in this application is true and correct.

_____ _____
signature date

DHS/DSLS Form 96 (Rev. 12-91)

Historical Note
Exhibit A moved from Section R9-14-408 and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT B
APPLICATION FOR A CLASS I OPERATOR PERMIT

ARIZONA DEPARTMENT OF HEALTH SERVICES
Division of State Laboratory Services
1520 West Adams Street
Phoenix, Arizona 85007
(602) 542-1188

DO NOT WRITE
IN THIS AREA
Permit_____
Date issued_____
Approved by_____

Application for a Class I operator permit as an operator of a breath testing or collecting device.

TO BE COMPLETED BY APPLICANT PLEASE PRINT CLEARLY
(ALL ITEMS MUST BE COMPLETED OR APPLICATION WILL NOT BE ACCEPTED)

DO YOU HAVE AN OPERATOR'S PERMIT? YES ____ NO ____ PERMIT NUMBER _____

1. Name: _____
(last) (first) (middle) (maiden)
2. Date of Birth: _____ 3. Social Security No.:_____ (optional)
4. Employer's Name: _____
5. Employer's Address: _____
6. Type of Device: _____
7. Agency Conducting Training: _____
8. Date and Place of Training: _____
9. Hours of Lecture Training: _____
10. Hours of Practical Training: _____

I hereby certify that the information submitted in this application is true and correct.

_____ _____
signature of applicant date

TO BE COMPLETED BY TRAINING OFFICER INSTRUCTOR

1. Arizona Department of Health Services training course number: _____
2. Did applicant successfully complete the course? Pass ____ Fail ____

_____
signature of instructor print name date

DHS/DSLS Form 95 (Rev. 12-91)

Historical Note
Exhibit B moved from Section R9-14-408 and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT C
APPLICATION FOR APPROVAL AS AN INSTRUCTOR IN THE USE OF A BREATH TESTING OR COLLECTING DEVICE

ARIZONA DEPARTMENT OF HEALTH SERVICES
Division of State Laboratory Services
1520 West Adams Street
Phoenix, Arizona 85007
(602) 542-1188

DO NOT WRITE
IN THIS AREA
Permit_____
Date issued_____
Approved by_____

Application for approval as an instructor in the use of a breath testing or collecting device.

TO BE COMPLETED BY APPLICANT PLEASE PRINT CLEARLY
(ALL ITEMS MUST BE COMPLETED OR APPLICATION WILL NOT BE ACCEPTED)

DO YOU HAVE A CLASS I AND CLASS II OPERATOR'S PERMIT? YES _____ PERMIT NUMBER _____

NO _____

1. Name: _____
   (last) (first) (middle) (maiden)
2. Employer's Name: _____
3. Employer's Address: _____
4. Instructor approval requested for which device(s): _____
   _____
5. Approval applied for under:
   (check where applicable and attach appropriate documentation)
   A.A.C. R9-14-406(C)(1) _____ _____
   agency/instructor conducting training date completed
   A.A.C. R9-14-406(C)(2) _____ _____
   examination score

I hereby certify that the information submitted in this application is true and correct.

_____ _____
signature of applicant date

TO BE COMPLETED BY INSTRUCTOR

1. Arizona Department of Health Services instructor training course number:_____
2. Did applicant successfully complete the course? Pass _____ Fail _____

_____ _____ _____
signature of instructor print name date

DHS/DSLS/Form 99 (Rev. 12-91)

Historical Note
Exhibit C moved from Section R9-14-408 and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT D
APPLICATION FOR A CLASS II OPERATOR PERMIT

ARIZONA DEPARTMENT OF HEALTH SERVICES
Division of State Laboratory Services
1520 West Adams Street
Phoenix, Arizona 85007
(602) 542-1188

DO NOT WRITE
IN THIS AREA
Permit_____
Date issued_____
Approved by_____

Application for a Class II operator permit, quality assurance specialist, for breath testing and/or collection devices.

TO BE COMPLETED BY APPLICANT PLEASE PRINT CLEARLY
(ALL ITEMS MUST BE COMPLETED OR APPLICATION WILL NOT BE ACCEPTED)

DO YOU HAVE A CLASS I OPERATOR PERMIT? YES _____ PERMIT NUMBER_____
NO _____

1. Name:_____
(last) (first) (middle) (maiden)
2. Employer's Name: _____
3. Employer's Address: _____
4. Class II operator permit requested for which device(s): _____
_____
5. Class II operator permit applied for under:
(check where applicable and attach appropriate documentation)

A.A.C. R9-14-406(D)(1) _____ _____
training conducted by date

A.A.C. R9-14-406(D)(2) _____ _____
examination score

I hereby certify that the information submitted in this application is true and correct.

_____ _____
signature of applicant date

TO BE COMPLETED BY TRAINING AGENCY

1. Arizona Department of Health Services instructor training course number:_____
2. Did applicant successfully complete the course? Pass ____ Fail _____

_____ _____ _____
signature/training agency print name date

DHS/DSLS/Form 103 (Rev. 12-91)

Historical Note
Exhibit D moved from Section R9-14-408 and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT E
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
BREATHALYZER 900/900A

AGENCY_____

NAME OF SUBJECT_____ DATE _____

INSTRUMENT NO._____ AMPUL CONTROL NO. _____

LOCATION OF TEST_____ TIME OF TEST_____

OPERATOR _____

TEST RESULTS 0._____ AC

Immediately preceding the administration of the test the subject was observed for 20 minutes from ____ to ____ by _____

( ) 1. SWITCH "ON", insure THERMOMETER shows 50° C ± 3° C. Affix test record card.
( ) 2. Gauge an AMPUL and insert in left-hand holder.
( ) 3. Gauge an AMPUL, open, re-gauge, insert in right-hand holder, insert BUBBLER and connect to outlet.
( ) 4. Turn to "TAKE", flush out instrument with squeeze bulb, turn to "ANALYZE".
( ) 5. When red "EMPTY" signal appears, wait 1-1/2 minutes, turn on LIGHT and BALANCE.
( ) 6. Ink BLOOD ALCOHOL POINTER, set pointer on START line and mark TEST RECORD CARD.
( ) 7. Turn to "TAKE", take breath sample, turn to "ANALYZE" (record time of test _____).
( ) 8. When RED empty signal appears, wait 1-1/2 minutes, turn on LIGHT, BALANCE and record the reading on the TEST RECORD CARD.
( ) 9. REMOVE TEST AMPUL AND TURN CONTROL KNOB TO "OFF".

DHS/DSLS/Form C101 (Rev. 12-91)

Historical Note
Exhibit E moved from Section R9-14-405 and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT EE
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE

BREATHALYZER 900/900A
DUPLICATE TEST

AGENCY_____

NAME OF SUBJECT_____ DATE _____

INSTRUMENT NO._____ AMPUL CONTROL NO. _____

LOCATION OF TEST_____

OPERATOR _____

TEST RESULTS 0._____ AC TIME _____

0._____ _____

0._____ _____

Immediately preceding the administration of the tests, the subject underwent a 15-minute deprivation period from _____ to _____ by _____.

( ) 1. SWITCH "ON", insure THERMOMETER shows 50° C ± 3° C. Affix test record card.
( ) 2. Gauge an AMPUL and insert in left-hand holder.
( ) 3. Gauge an AMPUL, open, re-gauge, insert in right-hand holder, insert BUBBLER and connect to outlet.
( ) 4. Turn to "TAKE", flush out instrument with squeeze bulb, turn to "ANALYZE".
( ) 5. When red "EMPTY" signal appears, wait 1-1/2 minutes, turn on LIGHT and BALANCE.
( ) 6. Ink BLOOD ALCOHOL POINTER, set pointer on START line and mark TEST RECORD CARD.
( ) 7. Turn to "TAKE", take breath sample, turn to "ANALYZE" (record time of test _____).
( ) 8. When RED empty signal appears, wait 1-1/2 minutes, turn on LIGHT, BALANCE and record the reading on the TEST RECORD CARD.
( ) 9. REMOVE TEST AMPUL AND TURN CONTROL KNOB TO "OFF".
( ) 10. Repeat steps 1 thru 9.

Note: Duplicate tests shall be between 5 and 10 minutes apart. Two consecutive tests shall agree within 0.020 alcohol concentration.

DHS/DSLS/Form C123

Historical Note
Exhibit EE adopted effective August 27, 1992 (Supp. 92-3).

EXHIBIT F
THIS REPORT PREPARED PURSUANT TO DUTY IMPOSED BY A.A.C. R9-14-404(A)

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD QUALITY ASSURANCE PROCEDURES
BREATHALYZER 900/900A

Agency_____Date_____
QA Specialist_____
(Print Name)
Breathalyzer serial #_____Location _____

_____ Temperature of sample chamber 50° C ± 3° C
_____ Photoelectric system balance
_____ Output of sample chamber satisfactory
_____ Delivery time 25 to 45 seconds:
Actual time _____ seconds.
_____ Timer cycle 85 to 95 seconds:
Actual time _____ seconds (900A only)

Calibration standard 0._____ AC.

Results: _____ AC Difference _____ AC
Operational condition _____
_____
Repairs or Adjustments _____
_____

Signature_____

DHS/DSLS/Form C102 (Rev. 12-91)

Historical Note
Exhibit F moved from Section R9-14-405 and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT G
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
GCI FIELD COLLECTION UNIT

AGENCY _____
NAME OF SUBJECT _____ DATE _____
KIT SEALED PRIOR TO USE - YES _____ NO _____ LOCATION OF TEST _____
OPERATOR _____
TIME SAMPLE COLLECTED _____ KIT RESEALED - YES _____ NO _____
KIT DELIVERED TO _____ DATE _____ TIME _____

Immediately preceding the administration of the test, the subject was observed for 20 minutes from _____ to _____ by _____.

( ) 1. Attach mouthpiece and check valve to template.
( ) 2. Insert template in crimper, lock in place, mount handle, remove cord and close box top.
( ) 3. Plug in crimper (red light on). Allow ten minutes warm-up. Check thermometer range 39-45° C (in green arc).
( ) 4. Obtain breath sample. Record date and time on carton.
( ) 5. Remove template, inspect crimp, record jaw number _____
( ) 6. Repack template in kit box, seal and mark seal.

DHS/DSLS/Form C103 (Rev. 12-91)

Historical Note
Exhibit G moved from Section R9-14-405 and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT H
THIS REPORT PREPARED PURSUANT TO DUTY IMPOSED BY A.A.C. R9-14-404(A)

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD QUALITY ASSURANCE PROCEDURE
GCI FIELD COLLECTION UNIT

Agency _____ QA Specialist _____
(Print Name)
GCI FCU # _____ LOCATION _____
DATE _____ TIME _____

_____ CORD AND CHECK VALVE PRESENT WITH UNIT.
_____ CRIMPING JAWS ALIGN PROPERLY UPON CLOSURE WITH ACTUATING HANDLE.
_____ CRIMPING JAWS ACHIEVE PROPER CLOSURE.
_____ UNIT WARMS UP TO PROPER TEMPERATURE RANGE IN 10 MINUTES OR LESS.
WARM UP TIME = _____

GENERAL CONDITION: _____
_____
REPAIRS OR ADJUSTMENTS: _____
_____

SIGNATURE_____

DHS/DSLS/Form C104 (Rev. 12-91)

Historical Note
Exhibit H moved from Section R9-14-405 and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT I
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
MARK IV GCI

AGENCY_____
NAME OF SUBJECT_____ DATE _____
INSTRUMENT NO._____ LOCATION OF TEST _____
OPERATOR _____ TIME OF TEST _____
TEST RESULTS 0._____ AC
Immediately preceding the administration of the test, the subject was observed for 20 minutes from _____ to _____ by _____.

( )1. OPERATE/STANDBY switch in STANDBY position.
( )2. Push OPERATE/STANDBY switch to OPERATE position. Wait until steady green light comes on.
( )3. Depress and release RESET button. Observe +.00 Digital Readout.
( )4. Depress and release ANALYZE button for blank reading.
( )5. Reading +.00.
( )6. Affix mouthpiece, take breath sample. Observe results in 90 seconds (record result and time of test).
( )7. Push OPERATE/STANDBY switch to STANDBY and push RESET.
( )8. Remove RECORDER STRIP CHART, attach it to ALCOHOL INFLUENCE REPORT and add subject's name to STRIP CHART.

DHS/DSLS/Form C105 (Rev. 12-91)

Historical Note
Exhibit I moved from Section R9-14-405 and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT II
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
MARK IV GCI

DUPLICATE TEST

AGENCY_____

NAME OF SUBJECT_____ DATE _____

INSTRUMENT NO._____ LOCATION OF TEST _____

OPERATOR _____ TIME OF TEST _____

TEST RESULTS	0._____ AC	TIME _____
	0._____	_____
	0._____	_____

Immediately preceding the administration of the tests, the subject underwent a 15-minute deprivation period from _____ to _____ by _____.

( )1. OPERATE/STANDBY switch in STANDBY Position.
( )2. Push OPERATE/STANDBY switch to OPERATE position. Wait until steady green light comes on.
( )3. Depress and release RESET button. Observe +.00 Digital Readout.
( )4. Depress and release ANALYZE button for blank reading.
( )5. Reading +.00.
( )6. Affix mouthpiece, take breath sample. Observe results in 90 seconds (record result and time of test).
( )7. Push OPERATE/STANDBY switch to STANDBY and push RESET.
( )8. If proper duplicate tests have not been obtained, repeal steps 2 thru 7.
( )9. Remove RECORDER STRIP CHART, attach it to ALCOHOL INFLUENCE REPORT and add subject's name to STRIP CHART.

Note: Duplicate tests shall be between 5 and 10 minutes apart. Two consecutive tests shall agree within 0.020 alcohol concentration.

DHS/DSLS/Form C125 (Rev. 7-93)

Historical Note

Exhibit II adopted effective August 27, 1992 (Supp. 92-3). Amended effective February 28, 1994 (Supp. 94-1).

EXHIBIT J
THIS REPORT PREPARED PURSUANT TO DUTY IMPOSED BY A.A.C. R9-14-404(A)

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD QUALITY ASSURANCE PROCEDURES
MARK IV GCI

A. PROCEDURE FOR CALIBRATION CHECKS AND CRITERIA FOR TESTING AND ENSURING PROPER OPERATION

1. Perform initial calibration check by running one blank analysis followed by an alcohol standard.
2. Fill out the calibration and maintenance record.
3. The instrument is considered operating properly if it is found to be capable of determining the value of a known alcohol standard within ±.01 alcohol concentration or ± 10% whichever is greater.
4. At least one calibration standard will be used during a calibration check.
5. Operational controls and alcohol-free subject testing are included in initial calibration check.

B. GAS CHROMATOGRAPH INTOXIMETER CALIBRATION AND MAINTENANCE RECORD

Agency _____ QA Specialist _____
(print name)

GCI _____ LOCATION _____ DATE _____ 19_

CALIBRATION A STANDARD 0. _____ AC

ACTUAL READING 0. _____ AC DIFFERENCE 0. _____ AC.

OPERATIONAL CONDITION- PROPER AND ACCURATE - YES _____ NO _____.

_____

_____

REPAIRS OR ADJUSTMENTS_____

_____

_____

SIGNATURE_____

DHS/DSLS/Form C106 (Rev. 12-91)

Historical Note

Exhibit J moved from Section R9-14-405 and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT K
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
INTOXILYZER MODELS 4011A MODIFIED & 4011AS MODIFIED*

AGENCY _____
NAME OF SUBJECT _____ DATE _____
INSTRUMENT SERIAL NO. _____ LOCATION OF TEST
_____
OPERATOR _____ TIME OF TEST _____
TEST RESULTS 0. _____ AC SAMPLE COLLECTED - YES _____ NO _____

Immediately preceding the administration of the test, the subject was observed for 20 minutes from _____ to _____ by _____.

( ) 1. Power switch is in "ON" position and the green "READY" light is illuminated.
( ) 2. Insert a test record card.
( ) 3. Connect breath tube to the pump tube.
( ) 4. Turn Mode Selector Switch to "Zero Set." Adjust Zero Set Control so that a .003, .002, .001 or .000 is displayed.
( ) 5. Turn Mode Selector Switch to "Air Blank."
( ) 6. After cycle is completed, turn Mode Selector to "Zero Set." Recheck "Zero Set" to verify proper setting.
( ) 7. Turn Mode Selector Switch to "Breath Test." Disconnect the breath tube from the pump tube. Insert a mouthpiece into the breath tube. Have subject blow into the instrument as long as possible until a printout is obtained.
( ) 8. A. If a sample is to be collected, remove the plastic caps from the breath collection tube and insert the end of the tube into the exhaust tube of the instrument.
OR
( ) B. If a sample is not to be collected, continue to step 9.
( ) 9. Connect Breath Tube to the Pump Tube. Turn Mode Selector Switch to "Air Blank."
( ) 10. When pump stops, if sample was collected, remove breath collection tube and firmly cap both ends.
( ) 11. Remove test record card.
( ) 12. Push breath tube back into instrument.

***WITH OR WITHOUT BEAN ATTENUATOR**

DHS/DSLS/Form C109 (Rev. 12-91)

Historical Note
Exhibit K moved from Section R9-14-405 and repealed, new Exhibit K renumbered from Exhibit M and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT KK
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
INTOXILYZER MODELS 4011A MODIFIED & 4011AS MODIFIED*

DUPLICATE TEST

AGENCY _____

NAME OF SUBJECT _____ DATE _____

INSTRUMENT SERIAL NO. _____ LOCATION OF TEST _____

OPERATOR _____ TIME OF TEST _____

TEST RESULTS	0. _____ AC	TIME _____	SAMPLE COLLECTED - YES _____	NO _____	
	0. _____	_____	_____	_____	
	0. _____	_____	_____	_____	

Immediately preceding the administration of the test the subject underwent a 15-minute deprivation period from _____ to _____ by _____.

( ) 1. Power switch is in "ON" position and the green "READY" light is illuminated.
( ) 2. Insert a test record card.
( ) 3. Connect breath tube to the pump tube.
( ) 4. Turn Mode Selector Switch to "Zero Set." Adjust Zero Set Control so that a .003, .002, .001 or .000 is displayed.
( ) 5. Turn Mode Selector Switch to "Air Blank."
( ) 6. After cycle is completed, turn Mode Selector to "Zero Set." Recheck "Zero Set" to verify proper setting.
( ) 7. Turn Mode Selector Switch to "Breath Test." Disconnect the breath tube from the pump tube. Insert a mouthpiece into the breath tube. Have subject blow into the instrument as long as possible until a printout is obtained.
( ) 8. A. If a sample is to be collected, remove the plastic caps from the breath collection tube and insert the end of the tube into the exhaust tube of the instrument.

OR

( ) B. If a sample is not to be collected, continue to step 9.
( ) 9. Connect Breath Tube to the Pump Tube. Turn Mode Selector Switch to "Air Blank."
( ) 10. When pump stops, if sample was collected, remove breath collection tube and firmly cap both ends.
( ) 11. Repeat steps 3 thru 10.
( ) 12. Remove test record card.
( ) 13. Push breath tube back into instrument.

Note: Duplicate tests shall be between 5 and 10 minutes apart. Two consecutive tests shall agree within 0.020 alcohol concentration.

***WITH OR WITHOUT BEAM ATTENUATOR**

DHS/DSLS/Form C127

Historical Note
Exhibit KK adopted effective August 27, 1992 (Supp. 92-3).

EXHIBIT L
THIS REPORT PREPARED PURSUANT TO DUTY IMPOSED BY A.A.C. R9-14-404(A)

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD QUALITY ASSURANCE PROCEDURES
INTOXILYZER MODELS 4011A MODIFIED & 4011AS MODIFIED

STANDARD CALIBRATION CHECK PROCEDURE*

Agency _____ Date _____ Time _____
Intoxilyzer Serial # _____ Location _____
QA Specialist _____
(Print Name)

( ) 1. Pour a standard alcohol solution of known value into a clean dry simulator jar and assemble the simulator. Insure that a tight seal has been made. Standard value: _____ AC.
( ) 2. Plug in the simulator and allow the temperature to reach 34°C ±.2° C.
( ) 3. The Intoxilyzer is turned on and the green "ready" light is illuminated.
( ) 4. Insert the test record card.
( ) 5. Turn the Mode Selector switch to "Zero Set." Adjust the Zero Set Control until a .003, .002, .001 or .000 is displayed.
( ) 6. Connect the pump tube to the breath tube and turn the Mode Selector switch to "Air Blank."
( ) 7. After the cycle is complete, turn the Mode Selector to "Zero Set." Recheck "Zero Set" to verify proper setting.
( ) 8. Connect the pump tube to the simulator inlet. Connect the breath tube to the simulator outlet. (Double check the Intoxilyzer-Simulator connections for correctness).
( ) 9. Turn the Mode Selector switch to "Calibrator." At the end of the cycle, record the displayed three-digit result.
Test result: _____ AC
( ) 10. Disconnect the simulator from the Intoxilizer. Connect the pump tubes to the breath tube. Turn Mode Selector switch to "Air Blank."
( ) 11. At the completion of the "Air Blank" cycle, return the Mode Selector switch to "Zero Set."
( ) 12. Remove the test record card and attach the test record card to the completed checklist.

SIGNATURE_____

*FOR DEVICES WITH OR WITHOUT SAMPLE PRESERVATION MODIFICATION OR BEAM ATTENUATOR

DHS/DSLS/Form C110 (Rev 12-91)

Historical Note
Exhibit L moved from Section R9-14-405 and repealed, new Exhibit L renumbered from Exhibit N and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT M
THIS REPORT PREPARED PURSUANT TO DUTY IMPOSED BY A.A.C. R9-14-404(A)

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD QUALITY ASSURANCE PROCEDURES
INTOXILYZER MODELS 4011A MODIFIED & 4011AS MODIFIED*

Agency _____ QA Specialist _____
(Print Name)
INTOXILYZER SERIAL # _____ LOCATION _____
DATE _____ 19____ TIME _____

_____ Instrument ON and green READY light illuminates.
_____ ZERO ADJUST function operational.
_____ AIR BLANK cycle time to completion = _____ seconds.
_____ Test on alcohol-free subject gives _____ AC result and instrument prints result in _____ seconds minimum time.
_____ ERROR recognition logic system functioning.
_____ Proper sample recognition system functioning.
_____ Completeness of sample purge with collection tube.**
CALIBRATION STANDARD __.____ AC.
RESULTS: __.____
Instrument operating properly and accurately - Yes _____ No _____
COMMENTS:_____
_____
_____
_____
_____

SIGNATURE _____

_____ AC standard collected for subsequent analysis. **

* FOR DEVICES WITH OR WITHOUT SAMPLE PRESERVATION MODIFICATION OR BEAM ATTENUATOR
** THIS STEP IS ONLY REQUIRED IF THIS DEVICE IS BEING USED FOR SAMPLE CAPTURE.

DHS/DSLS/Form C111 (Rev. 12-91)

Historical Note
Exhibit M moved from Section R9-14-405 and renumbered to Exhibit K; new Exhibit M renumbered from Exhibit O and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT N
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
INTOXILYZER MODELS 4011A MODIFIED & 4011AS MODIFIED*
SAMPLE PRESERVATION MODIFICATION

AGENCY _____
NAME OF SUBJECT _____ DATE _____
INSTRUMENT SERIAL NO. _____ LOCATION OF TEST _____
OPERATOR _____ TIME OF TEST _____
TEST RESULTS 0._____ AC SAMPLE COLLECTED - YES _____ NO _____

Immediately preceding the administration of the test, the subject was observed for 20 minutes from _____ to _____ by _____.

( ) 1. Power switch is in "ON" position and the green "READY" light is illuminated.
( ) 2. Insert a test record card.
( ) 3. Connect breath tube to the pump tube.
( ) 4. Turn Mode Selector Switch to "Zero Set." Adjust Zero Set Control so that a .003, .002, .001 or .000 is displayed.
( ) 5. Turn Mode Selector Switch to "Air Blank."
( ) 6. After cycle is completed, turn Mode Selector to "Zero Set." Recheck "Zero Set" to verify proper setting.
( ) 7. Turn Mode Selector Switch to "Breath Test." Disconnect the breath tube from the pump tube. Insert a mouthpiece into the breath tube. Have subject blow into the instrument as long as possible until a printout is obtained.
( ) 8. A. If a sample is to be collected, remove the plastic caps from the breath collection tube and insert the tube between the exhaust tube and suction tube of the instrument. DO NOT connect the pump tube to the breath tube.
OR
( ) B. If a sample is not to be collected, connect the Breath Tube to the Pump Tube.
( ) 9. Turn Mode Selector Switch to "Air Blank."
( ) 10. When pump stops, if sample was collected, remove breath collection tube and firmly cap both ends.
( ) 11. Remove test record card.
( ) 12. Push breath tube back into instrument.

*WITH OR WITHOUT BEAM ATTENUATOR

DHS/DSLS/Form C114 (Rev. 12-91)

Historical Note
Exhibit N moved from Section R9-14-405 and renumbered to Exhibit L, new Exhibit N renumbered from Exhibit R and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT NN
OPERATOR CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
INTOXILYZER MODELS 4011A MODIFIED & 4011AS MODIFIED*
SAMPLE PRESERVATION MODIFICATION

DUPLICATE TEST

AGENCY _____
NAME OF SUBJECT _____DATE _____
INSTRUMENT SERIAL NO. _____ LOCATION OF TEST _____
OPERATOR _____ TIME OF TEST _____
TEST RESULTS 0._____ AC TIME _____ SAMPLE COLLECTED - YES _____ NO _____
0._____ _____ _____ _____
0._____ _____ _____ _____

Immediately preceding the administration of the tests, the subject underwent a 15-minute deprivation period from _____ to _____ by _____.

( ) 1. Power switch is in "ON" position and the green "READY" light is illuminated.
( ) 2. Insert a test record card.
( ) 3. Connect breath tube to the pump tube.
( ) 4. Turn Mode Selector Switch to "Zero Set." Adjust Zero Set Control so that a .003, .002, .001 or .000 is displayed.
( ) 5. Turn Mode Selector Switch to "Air Blank."
( ) 6. After cycle is completed, turn Mode Selector to "Zero Set." Recheck "Zero Set" to verify proper setting.
( ) 7. Turn Mode Selector Switch to "Breath Test." Disconnect the breath tube from the pump tube. Insert a mouthpiece into the breath tube. Have subject blow into the instrument as long as possible until a printout is obtained.
( ) 8. A. If a sample is to be collected, remove the plastic caps from the breath collection tube and insert the tube between the exhaust tube and suction tube of the instrument. DO NOT connect the pump tube to the breath tube.
OR
( ) B. If a sample is not to be collected, connect the Breath Tube to the Pump Tube.
( ) 9. Turn Mode Selector Switch to "Air Blank."
( ) 10. When pump stops, if sample was collected, remove breath collection tube and firmly cap both ends.
( ) 11. Repeat Steps 3 thru 10.
( ) 11. Remove test record card.
( ) 12. Push breath tube back into instrument.

Note: Duplicate tests shall be between 5 and 10 minutes apart. Two consecutive tests shall agree within 0.020 alcohol concentration.

*WITH OR WITHOUT BEAM ATTENUATOR

DHS/DSLS/Form C128

Historical Note
Exhibit NN adopted effective August 27, 1992 (Supp. 92-3).

EXHIBIT O
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
INTOXILYZER MODEL 5000*

AGENCY _____
NAME OF SUBJECT _____ DATE _____
INSTRUMENT SERIAL NO. _____ LOCATION OF TEST _____
OPERATOR _____ TIME OF TEST _____
TEST RESULTS 0._____ AC SAMPLE COLLECTED YES _____ NO _____

Immediately preceding the administration of the test, the subject was observed for 20 minutes from _____ to _____ by _____.

( ) 1. Display reads "READY TO START" or "PUSH BUTTON TO START TEST". Breath tube is warm to touch.
( ) 2. Push Start Test button.
( ) 3. Insert card in response to display.
( ) 4. Air Blank completed.
( ) 5. Insert mouthpiece into breath tube. Have subject blow as long as possible. Result 0._____ AC.
( ) 6. a. If this sample is to be saved, remove end caps and attach collector device. Push Start Test button.
OR
b. If this sample is not to be saved, push Start Test button immediately.
OR
c, If sample purge begins immediately, go to step 7.
( ) 7. Air blank completed.
( ) 8. a. If a sample is saved, detach collector device and firmly cap both ends. Push Start Test button.
OR
b. If a sample is not saved, push Start Test button immediately.
OR
c. If display reads "TEST COMPLETE", go to step 9.
( ) 9. When display reads "TEST COMPLETE", remove test record card.

*WITH OR WITHOUT VAPOR RECIRCULATION

DHS/DSLS/Form C115 (Rev. 12-91)

Historical Note

Exhibit O moved from Section R9-14-405 and renumbered to Exhibit M, new Exhibit O renumbered from Exhibit S and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT OO
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
INTOXILYZER MODEL 5000*

DUPLICATE TEST - WITH SAMPLE CAPTURE OPTION

AGENCY _____
NAME OF SUBJECT _____ DATE _____
INSTRUMENT SERIAL NO. _____ LOCATION OF TEST _____
OPERATOR _____ TIME OF TEST _____

TEST RESULTS	0. _____	AC	TIME _____	SAMPLE COLLECTED - YES _____	NO _____
	0. _____		_____	_____	_____
	0. _____		_____	_____	_____

Immediately preceding the administration of the tests, the subject underwent a 15-minute deprivation period from _____ to _____ by _____.

( ) 1. Display reads "READY TO START" or "PUSH BUTTON TO START TEST". Breath tube is warm to touch.
( ) 2. Push Start Test button.
( ) 3. Insert card in response to display.
( ) 4. Air Blank completed.
( ) 5. Insert mouthpiece into breath tube. Have subject blow as long as possible. Record results above.
( ) 6. a. If this sample is to be saved, remove end caps and attach collector device. Push Start Test button.
OR
b. If this sample is not to be saved, push Start Test button immediately.
OR
c, If sample purge begins immediately, go to step 7.
( ) 7. Air blank completed.
( ) 8. a. If a sample is saved, detach collector device and firmly cap both ends. Push Start Test button.
OR
b. If a sample is not saved, push Start Test button immediately.
OR
c. If display reads "TEST COMPLETE", go to step 9.
( ) 9. When display reads "TEST COMPLETE", remove test record card.
( ) 10. Repeal steps 1 thru 9.

Note: Duplicate tests shall be between 5 and 10 minutes apart. Two consecutive tests shall agree within 0.020 alcohol concentration.

*WITH OR WITHOUT VAPOR RECIRCULATION

DHS/DSLS/Form C129 (rev. 7-93)

Historical Note
Exhibit OO adopted effective August 27, 1992 (Supp. 92-3). Amended effective February 28, 1994 (Supp. 94-1).

EXHIBIT OOO
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
INTOXILYZER MODEL 5000*

DUPLICATE TEST - WITHOUT SAMPLE CAPTURE OPTION

AGENCY _____

NAME OF SUBJECT _____ DATE _____

INSTRUMENT SERIAL NO. _____ LOCATION OF TEST _____

OPERATOR _____ TIME OF TEST _____

TEST RESULTS	0._____ AC	TIME	_____
	0._____		_____
	0._____		_____

Immediately preceding the administration of the tests, the subject underwent a 15-minute deprivation period from _____ to _____ by _____.

( ) 1. Display reads "READY TO START" or "PUSH BUTTON TO START TEST". Breath tube is warm to touch.
( ) 2. Push Start Test button.
( ) 3. If display reads "INSERT CARD", do so.
( ) 4. Air Blank completed.
( ) 5. Insert mouthpiece into breath tube. Have subject blow as long as possible. Record results above.
( ) 6. Air blank completed.
( ) 7. a. If display reads "WAIT", go to step 8.
OR
b. If display reads "TEST COMPLETE", go to step 9.
( ) 8. Repeat steps 1 thru 7.
( ) 9. When display reads "TEST COMPLETE", remove test record card. If duplicate tests have not been obtained between 5 and 10 minutes apart with a .020 AC agreement, repeat steps 1 thru 7.

Note: Duplicate tests shall be between 5 and 10 minutes apart. Two consecutive tests shall agree within 0.020 alcohol concentration.

*WITH OR WITHOUT VAPOR RECIRCULATION

DHS/DSLS/Form C134

Historical Note
Exhibit OOO adopted effective February 28, 1994 (Supp. 94-1).

EXHIBIT P
THIS REPORT PREPARED PURSUANT TO DUTY IMPOSED BY A.A.C. R9-14-404(A)

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD QUALITY ASSURANCE PROCEDURES
INTOXILYZER MODEL 5000*

STANDARD CALIBRATION CHECK PROCEDURE

Agency _____ Date _____ Time _____
Intoxilyzer Serial # _____ Location _____
QA Specialist _____
(Print Name)

( ) 1. Pour a standard alcohol solution of known value into a clean dry simulator jar and assemble the simulator. Insure that a tight seal has been made. Standard value: 0.____ AC
( ) 2. Turn on the simulator and allow the temperature to reach 34° C ±.2°C.
( ) 3. Set Intoxilyzer mode selection in the ACA mode by switching mode selection switch #9 on or selecting "C" on keyboard menu.
( ) 4. Attach simulator to the simulator entrance port on the Intoxilyzer.
( ) 5. Intoxilyzer 5000 display reads "READY TO START" or "PUSH BUTTON".
( ) 6. Push Start Test button or press enter on keyboard.
( ) 7. Insert card in response to display.
( ) 8. Air blank completed.
( ) 9. Calibration check completed. Test results 0.____ AC
( ) 10. Air blank completed.
( ) 11. When display reads Test Complete, remove evidence card. Attach the card to the completed checklist.
( ) 12. Return mode selection switch #9 to off position after all calibration checks are complete or type Q and enter on keyboard.

SIGNATURE_____

*WITH OR WITHOUT VAPOR RECIRCULATION AND WITH OR WITHOUT KEYBOARD

DHS/DSLS/Form C116 (Rev. 7-93)

Historical Note
Exhibit P moved from Section R9-14-405 and repealed, new Exhibit P renumbered from Exhibit T and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT PP
THIS REPORT PREPARED PURSUANT TO DUTY IMPOSED BY A.A.C. R9-14-404(A)

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD QUALITY ASSURANCE PROCEDURES
INTOXILYZER MODEL 5000* WITH VAPOR RECIRCULATION AND WITH KEYBOARD

STANDARD CALIBRATION CHECK PROCEDURE

1. Ensure simulator on and contains a standard calibration solution of known value, 0.100 AC, at temperature of 34°C ±.2°C.
2. Intoxilyzer display reads "READY TO START" or "PUSH BUTTON".
3. Set Intoxilyzer mode selection in the ACA mode by selecting "C" on the keyboard menu.
4. Press ENTER on keyboard.
5. Air blank completed.
6. Calibration check completed.
7. Confirm calibration reading is in .090 to .110 range.
8. Air blank completed.
9. Test complete.

Instrument reading is within acceptable accuracy limits. Enter "Y" or "N".

DHS/DSLS/Form C135

Historical Note
Exhibit PP adopted effective February 28, 1994 (Supp. 94-1).

EXHIBIT Q
THIS REPORT PREPARED PURSUANT TO DUTY IMPOSED BY A.A.C. R9-14-404(A)

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD QUALITY ASSURANCE PROCEDURES
INTOXILYZER MODEL 5000*

AGENCY _____ QA SPECIALIST _____
(Print Name)
INTOXILYZER SERIAL # _____ LOCATION _____
DATE _____19____ TIME _____

_____ Display reads "READY TO START" or "PUSH BUTTON TO START TEST."

DIAGNOSTIC TESTS
_____ DVM Test check. Setting should be between .200 and .600. Mode selection switch S2 on, S1 and S3 off or keyboard menu selection "H". Reading is _____.
_____ Display Test check. Mode selection switch S1 on and S2 and S3 off or keyboard menu selection "V".
_____ Printer Test check. Mode selection switch S1, S2, S3 off or keyboard menu selection "P".
_____ Clock time check. Mode selection switch S10 on or keyboard menu selection "E".
_____ Date check. Mode selection switch S11 on or keyboard menu selection "E".

OPERATIONAL TESTS
_____ Alcohol-free subject Test result 0._____ AC
_____ Error recognition logic system functioning
Invalid test printed
_____ Proper sample recognition system
Invalid sample printed
Deficient sample printed
_____ Completeness of sample purge with collection tube **
_____ Calibration standard 0._____ AC Results: 0._____
Instrument operating properly and accurately. YES _____NO _____

COMMENTS:_____
_____
_____
_____
_____

SIGNATURE_____

0. Alcohol concentration standard collected for subsequent analysis.**

*WITH OR WITHOUT VAPOR RECIRCULATION AND WITH OR WITHOUT KEYBOARD
**THIS STEP IS ONLY REQUIRED IF THIS DEVICE IS BEING USED FOR SAMPLE CAPTURE.

DHS/DSLS/Form C117 (Rev. 7-93)

Historical Note
Exhibit Q moved from Section R9-14-405 and repealed, new Exhibit Q renumbered from Exhibit U and amended effective August 27, 1992 (Supp. 92-3). Amended effective February 28, 1994 (Supp. 94-1).

EXHIBIT QQ
THIS REPORT PREPARED PURSUANT TO DUTY IMPOSED BY A.A.C. R9-14-404(A)

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD QUALITY ASSURANCE PROCEDURES
INTOXILYZER MODEL 5000 WITH VAPOR RECIRCULATION AND WITH KEYBOARD

Display reads "READY TO START" or "PUSH BUTTON TO START TEST."

DIAGNOSTIC TESTS
1. DVM Test check. Value is between .200 and .600. Keyboard menu selection "H".
2. Display Test check. Keyboard menu selection "V".
3. Clock time check. Keyboard menu selection "E".
4. Date check. Keyboard menu selection "E".

OPERATIONAL TESTS
1. Alcohol-free subject Test result 0.000 AC.
2. Error recognition logic system functioning.
   Invalid test printed.
3. Proper sample recognition system.
   Invalid sample printed.
   Deficient sample printed.
4. Completeness of sample purge with collection tube *.
5. Calibration standard 0.100 AC.

Instrument operating properly and accurately. Enter "Y" or "N".

*THIS STEP IS ONLY REQUIRED IF THIS DEVICE IS BEING USED FOR SAMPLE CAPTURE.

DHS/DSLS/Form C136

Historical Note
Exhibit QQ adopted effective February 28, 1994 (Supp. 94-1).

EXHIBIT R
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
INTOXIMETER 3000

AGENCY _____
NAME OF SUBJECT _____ DATE _____
INSTRUMENT NO. _____ LOCATION OF TEST _____
OPERATOR _____ TIME OF TEST _____
TEST RESULTS 0. _____ AC

Immediately preceding the administration of the test, the subject was observed for 20 minutes from _____ to _____ by _____.

( ) 1. Display reads "Press Start to Test", Time and Date.
( ) 2. Affix mouthpiece.
( ) 3. Press START key. Follow IR3000 display procedure.
( ) 4. Enter operator's name - initials, last name, serial #.
( ) 5. Enter subject's name.
( ) 6. Enter DOB.
( ) 7. A. Correct standard and blank readings displayed.
( ) B. Subject blew until star appeared.
( ) 8. Remove printout and tape printout to Alcohol Influence Report.

DHS/DSLS/Form C118 (Rev. 12-91)

Historical Note
Exhibit R moved from Section R9-14-405 and renumbered to Exhibit N, New Exhibit R renumbered from Exhibit V and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT RR
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
INTOXIMETER 3000

DUPLICATE TEST

AGENCY _____
NAME OF SUBJECT _____ DATE _____
INSTRUMENT NO. _____ LOCATION OF TEST _____
OPERATOR _____ TIME OF TEST _____
TEST RESULTS 0. _____ AC TIME _____
0. _____ _____
0. _____ _____

Immediately preceding the administration of the tests, the subject underwent a 15-minute deprivation period from _____ to _____ by _____.

( ) 1. Display reads "Press Start to Test", Time and Date.
( ) 2. Affix mouthpiece.
( ) 3. Press START key. Follow IR3000 display procedure.
( ) 4. Enter operator's name - initials, last name, serial #.
( ) 5. Enter subject's name.
( ) 6. Enter DOB.
( ) 7. A. Correct standard and blank readings displayed.
( ) B. Subject blew until star appeared.
( ) 8. Repeat steps 1 thru 7.
( ) 9. Remove printout and tape printout to Alcohol Influence Report.

Note: Duplicate tests shall be between 5 and 10 minutes apart. Two consecutive tests shall agree within 0.020 alcohol concentration.

DHS/DSLS/Form C130

Historical Note
Exhibit RR adopted effective August 27, 1992 (Supp. 92-3).

EXHIBIT S
THIS REPORT PREPARED PURSUANT TO DUTY IMPOSED BY A.A.C. R9-14-404(A)

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD QUALITY ASSURANCE PROCEDURES
INTOXIMETER 3000

STANDARD CALIBRATION CHECK PROCEDURE

Agency _____ QA Specialist _____
(Print Name)
Serial # _____ Location _____
Date _____ 19_____ Time _____

( ) 1. Pour a standard alcohol solution of known value into a clean dry simulator jar and assemble the simulator. Insure that a tight seal has been made. Standard value: 0._____ AC
( ) 2. Turn on the simulator and allow the temperature to reach 34°C ±.2°C.
( ) 3. Display reads "Press Start to Test", Time and Date.
( ) 4. Press START key. Follow IR3000 display procedure.
( ) 5. Enter operator's name.
( ) 6. Enter "calibrate" as subject name.
( ) 7. Connect simulator to breath tube. Blow until star is displayed.
( ) 8. Calibration check completed. Test results A _____B _____
( ) 9. Attach printout.
Instrument operating accurately Yes _____ No _____

SIGNATURE_____

DHS/DSLS/Form C119 (Rev. 12-91)

Historical Note
Exhibit S moved from Section R9-14-405 and renumbered to Exhibit O, new Exhibit S renumbered from Exhibit W and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT T
THIS REPORT PREPARED PURSUANT TO DUTY IMPOSED BY A.A.C. R9-14-404(A)

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD QUALITY ASSURANCE PROCEDURES
INTOXIMETER 3000

AGENCY _____ QA SPECIALIST _____
(Print Name)
INTOXIMETER SERIAL # _____ LOCATION _____
DATE _____19____ TIME _____

_____Display reads "Press Start to Test", Time and Date.
DIAGNOSTIC TESTS
_____ Self test procedure operated properly.
_____ Printer test check.
_____ Clock time check.
_____ Date check.

OPERATIONAL TESTS
_____ Alcohol-free subject test result 0.___ AC
_____ Internal standard reads between .091 and .109.
_____ Proper sample recognition system functioning.

Instrument operating properly and accurately
YES _____ NO _____

COMMENTS:_____
_____
_____
_____
_____

SIGNATURE_____

DHS/DSLS/Form C120 (Rev. 12-91)

Historical Note
Exhibit T moved from Section R9-14-405 and renumbered to Exhibit P, new Exhibit T renumbered from Exhibit X and amended effective August 27, 1992 (Supp. 92-3).

EXHIBIT U
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
ALCO - SENSOR III

AGENCY _____
NAME OF SUBJECT _____ DATE _____
INSTRUMENT NO. _____ TEST LOCATION _____
OPERATOR _____

Immediately preceding the administration of the test, the subject was observed for 20 minutes from _____ to _____ by _____.
TEST RESULTS 0._____ AC

( ) 1. Have subject stop smoking. Smoke destroys the Alco Sensor: THE SUBJECT MUST STOP SMOKING 5 MINUTES BEFORE BEING TESTED.
( ) 2. Liquid crystal thermometer reads between 20°C and 36°C.
( ) 3. Attach fresh mouthpiece.
( ) 4. Press read button for 10 seconds. If display does not read less than .005, depress Set Button, wait 5 minutes and repeat this step. If display reads 888, replace the battery before the test.
( ) 5. Press Set button.
( ) 6. Have subject blow for a minimum of 4 seconds and press Read button. Subject can then stop blowing.
( ) 7. Keep Read button depressed until a maximum reading is obtained.
( ) 8. Write down result on Alcohol Influence Report Form.
( ) 9. Make sure the Set button is depressed at all times when not in use.

DHS/DSLS/Form C121

Historical Note
Exhibit U moved from Section R9-14-405 and renumbered to Exhibit Q, new Exhibit U adopted effective August 27, 1992 (Supp. 92-3).

EXHIBIT UU
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
ALCO - SENSOR III

Duplicate Test

AGENCY _____
NAME OF SUBJECT _____ DATE _____
INSTRUMENT NO. _____ TEST LOCATION _____
OPERATOR _____

Immediately preceding the administration of the tests, the subject underwent a 15-minute deprivation period from _____ to _____ by _____.

TEST RESULT 0._____ AC Time _____
0._____ _____
0._____ _____

( ) 1. Have subject stop smoking. Smoke destroys the Alco Sensor: THE SUBJECT MUST STOP SMOKING 5 MINUTES BEFORE BEING TESTED.
( ) 2. Liquid crystal thermometer reads between 20°C and 36°C.
( ) 3. Attach fresh mouthpiece.
( ) 4. Press read button for 10 seconds. If display does not read less than .005, depress Set Button, wait 5 minutes and repeat this step. If display reads 888, replace the battery before the test.
( ) 5. Press Set button.
( ) 6. Have subject blow for a minimum of 4 seconds and press Read button. Subject can then stop blowing.
( ) 7. Keep Read button depressed until a maximum reading is obtained.
( ) 8. Write down result on Alcohol Influence Report Form.
( ) 9. Press Set button to clear display. Wait at least 5 minutes before next test if alcohol was present. If no alcohol was detected, the unit may be used immediately.
( ) 10. Repeat steps 2 through 8.
( ) 11. Make sure the Set button is depressed at all times when not in use.

Note: Duplicate tests shall be given between 5 and 10 minutes apart. Two consecutive breath tests shall agree within 0.020 alcohol concentration.

DHS/DSLS/Form C131

Historical Note
Exhibit UU adopted effective August 27, 1992 (Supp. 92-3).

EXHIBIT V
THIS REPORT PREPARED PURSUANT TO DUTY IMPOSED BY A.A.C. R9-14-404(A)

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD QUALITY ASSURANCE PROCEDURES
ALCO-SENSOR III

A. PROCEDURE FOR CALIBRATION CHECKS AND CRITERIA FOR TESTING AND ENSURING PROPER OPERATION

1. Perform initial calibration check by running one blank analysis followed by an alcohol standard.
2. Fill out the calibration and maintenance record.
3. The instrument is considered operating property if it is found to be capable of determining the value of a known alcohol standard within ±.01 alcohol concentration or ± 10% whichever is greater.
4. At least one calibration standard shall be used during a calibration check.
5. Operational controls and alcohol-free subject testing are included in initial calibration check.

B. ALCO-SENSOR III CALIBRATION AND MAINTENANCE RECORD

Agency _____ QA SPECIALIST _____
(Print Name)

ALCO-SENSOR III _____ LOCATION _____

DATE _____ 19_____ Time _____

CALIBRATION STANDARD 0. _____ AC

ACTUAL READING 0. _____ AC DIFFERENCE 0._____ AC

OPERATION CONDITION- PROPER AND ACCURATE - YES _____NO _____

_____

_____

REPAIRS OR ADJUSTMENTS_____

_____

SIGNATURE_____

DHS/DSLS/Form C122

Historical Note

Exhibit V moved from Section R9-14-405 and renumbered to Exhibit R, new Exhibit V adopted effective August 27, 1992 (Supp. 92-3).

EXHIBIT W
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
INTOXILYZER MODEL 5000
WITH VAPOR RECIRCULATION WITH KEYBOARD

AGENCY _____
NAME OF SUBJECT _____ DATE _____
INSTRUMENT SERIAL NO. _____ LOCATION OF TEST _____
OPERATOR _____ TIME OF TEST _____
TEST RESULTS 0._____ AC SAMPLE COLLECTED YES _____ NO _____

Immediately preceding the administration of the test, the subject was observed for 20 minutes from _____ to _____ by _____.

( ) 1. Display reads "READY TO START" or "PUSH BUTTON TO START TEST". Breath tube is warm to touch.
( ) 2. Press Start Test button.
( ) 3. Insert card in response to display.
( ) 4. Input information in response to display.
( ) 5. Air Blank completed.
( ) 6. Insert mouthpiece into breath tube. Have subject blow as long as possible. Result 0. _____ AC.
( ) 7. a. If this sample is to be saved, remove end caps and attach collector device. Push Start Test button.
OR
( ) b. If this sample is not to be saved, push Start Test button immediately.
OR
( ) c. If sample purge begins immediately, go to step 8.
( ) 8. Air blank completed.
( ) 9. a. If this sample is saved, detach collector device and firmly can both ends. Push Start Test button.
OR
( ) b. If this sample is not saved, push Start Test button immediately.
OR
( ) c. If display reads "TEST COMPLETE", go to step 10.
( ) 10. When display reads "TEST COMPLETE", remove test record card.

DHS/DSLS/Form C132

Historical Note

Exhibit W moved from Section R9-14-405 and renumbered to Exhibit S, new Exhibit W adopted effective August 27, 1992 (Supp. 92-3).

EXHIBIT WW
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
INTOXILYZER MODEL 5000
WITH VAPOR RECIRCULATION WITH KEYBOARD

DUPLICATE TEST - WITH SAMPLE CAPTURE OPTION

AGENCY _____

NAME OF SUBJECT _____ DATE _____

INSTRUMENT SERIAL NO. _____ LOCATION OF TEST _____

OPERATOR _____ TIME OF TEST _____

TEST RESULTS	0._____	AC	TIME _____	SAMPLE COLLECTED - YES _____	NO _____
	0._____		_____	_____	_____
	0._____		_____	_____	_____

Immediately preceding the administration of the tests, the subject underwent a 15-minute deprivation period from _____ to _____ by _____.

( ) 1. Display reads "PUSH BUTTON TO START TEST" or "PRESS START TEST BUTTON TO START NEXT TEST". Breath tube is warm to touch.
( ) 2. Press Start Test button.
( ) 3. If display reads "Insert Card", do so.
( ) 4. Input information in response to display.
( ) 5. Air Blank completed.
( ) 6. Insert mouthpiece into breath tube. Have subject blow as long as possible. Record AC result above.
( ) 7. a. If this sample is to be saved, remove end caps and attach collector device. Push Start Test button.
OR
( ) b. If this sample is not to be saved, push Start Test button immediately.
OR
( ) c. If sample purge begins immediately, go to step 8.
( ) 8. Air blank completed.
( ) 9. a. If this sample is saved, detach collector device and firmly can both ends. Push Start Test button.
OR
( ) b. If this sample is not saved, push Start Test button immediately.
OR
( ) c. If display reads "TEST COMPLETE", go to step 10.
( ) 10. When display reads "TEST COMPLETE", remove test record card.
( ) 11. Repeat steps 1 thru 9.

Note: Duplicate tests shall be between 5 and 10 minutes apart. Two consecutive tests shall agree within 0.020 alcohol concentration.

DHS/DSLS/Form C133 (Rev. 7-93)

Historical Note
Exhibit WW adopted effective August 27, 1992 (Supp. 92-3). Amended effective February 28, 1994 (Supp. 94-1).

EXHIBIT WWW
OPERATIONAL CHECKLIST

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
INTOXILYZER MODEL 5000
WITH VAPOR RECIRCULATION WITH KEYBOARD

DUPLICATE TEST - WITHOUT SAMPLE CAPTURE OPTION

AGENCY _____
NAME OF SUBJECT _____ DATE _____
INSTRUMENT SERIAL NO. _____ LOCATION OF TEST _____
OPERATOR _____ TIME OF TEST _____
TEST RESULTS 0._____ AC TIME _____
0._____ _____
0._____ _____

Immediately preceding the administration of the tests, the subject underwent a 15-minute deprivation period from _____ to _____ by _____.

( ) 1. Display reads "PUSH BUTTON TO START TEST" or "PRESS START TEST BUTTON TO START NEXT TEST". Breath tube is warm to touch.
( ) 2. Press Start Test button.
( ) 3. If display reads "Insert Card", do so.
( ) 4. Input information in response to display.
( ) 5. Air Blank completed.
( ) 6. If display reads "IS SIMULATOR SOLUTION TEMPERATURE 34°C ± 0.2°C?", type Y or N and verify calibration check completed.
( ) 7. Insert mouthpiece into breath tube. Have subject blow as long as possible. Record AC result above.
( ) 8. Air blank completed.
( ) 9. a. If display reads "WAIT", go to step 11
OR
( ) b. If display reads "TEST COMPLETE". GO TO STEP 10.
OR
( ) c. If display reads "IS SIMULATOR SOLUTION TEMPERATURE 34°C ± 0.2°C?", type Y or N and verify calibration check completed. Go to step 10.
( ) 10. When display reads "TEST COMPLETE", remove test record card.
( ) 11. Repeat steps 1 thru 9.

Note: Duplicate tests shall be between 5 and 10 minutes apart. Two consecutive tests shall agree within 0.020 alcohol concentration.

DHS/DSLS/Form C137

Historical Note
Exhibit WWW adopted effective February 28, 1994 (Supp. 94-1).

EXHIBIT X
OPERATIONAL CHECKLIST

DEPARTMENT OF HEALTH SERVICES

STANDARD OPERATIONAL PROCEDURE
INTOXIMETER RBT IV

DUPLICATE TEST

AGENCY _____
NAME OF SUBJECT _____ DATE _____
RBT IV SERIAL NO. _____ ALCO-SENSOR IV SERIAL NO. _____
OPERATOR _____ LOCATION OF TEST _____

TEST RESULTS 0._____ AC TIME _____
0._____ _____
0._____ _____

Immediately preceding the administration of the tests, the subject underwent a 15-minute deprivation period from _____ to _____ by _____.

( ) 1. Turn on RBT IV.
( ) 2. Push start button.
( ) 3. Insert mouthpiece.
( ) 4. Device temperature registers between 10°C and 40°C.
( ) 5. Blank completed.
( ) 6. Press Set button.
( ) 7. Have subject blow as long as possible, sample captured.
( ) 8. Press Set Button.
( ) 9. Press red eject button to remove mouthpiece.
( ) 10. Remove test record when printout is complete.
( ) 11. Repeat steps 2 through 10 until a duplicate test is complete.
( ) 12. Turn off RBT IV.

Note: Duplicate tests shall be given between 5 and 10 minutes apart. Two consecutive tests shall agree within 0.020 alcohol concentration.

DHS/DSLS/Form C138

Historical Note
Exhibit X moved from Section R9-14-405 and renumbered to Exhibit T effective August 27, 1992 (Supp. 92-3). New Exhibit X adopted effective February 12, 1996 (Supp. 96-1).

EXHIBIT Y
THIS REPORT PREPARED PURSUANT TO DUTY IMPOSED BY A.A.C. R9-14-404(A)

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD QUALITY ASSURANCE PROCEDURES
INTOXIMETER RBT IV

STANDARD CALIBRATION CHECK PROCEDURE

Agency _____ Date _____
RBT IV SERIAL NO. _____ ALCO-SENSOR IV SERIAL NO. _____
QA Specialist _____ LOCATION _____
(Print Name)

( ) 1. Have a standard alcohol source of known value ready. This may be a simulator (at 34°C ± 0.2°C) or a dry gas alcohol standard.
Standard value: 0._____ AC.
( ) 2. Turn on RBT IV. Press START. Insert mouthpiece.
( ) 3. Device temperature registers between 10°C and 40°C.
( ) 4. Blank completed. Press SET button.
( ) 5. When RBT IV instructs user to "PROCEED WITH TEST", push STD OPTION button until the RBT IV displays "RUN STANDARD".
( ) 6. Attach alcohol source to mouthpiece.
( ) 7. Introduce standard into the Alco-Sensor IV for at least 4 seconds, at 3 seconds and while there is still gas flowing, press MANUAL button on the Alco-Sensor IV to take the sample.
( ) 8. Disconnect alcohol source from mouthpiece.
( ) 9. Press SET button.
( ) 10. Test results) 0._____ AC.
( ) 11. Press red eject button to remove mouthpiece.
( ) 12. Remove test record when printout is complete.
( ) 12. Turn off RBT IV.

SIGNATURE _____

DHS/DSLS/Form C139

Historical Note
Exhibit Y adopted effective February 12, 1996 (Supp. 96-1).

EXHIBIT Z
THIS REPORT PREPARED PURSUANT TO DUTY IMPOSED BY A.A.C. R9-14-404(A)

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDARD QUALITY ASSURANCE PROCEDURE
INTOXIMETER RBT IV

Agency _____ Date _____
RBT IV SERIAL NO. _____ ALCO-SENSOR IV SERIAL NO. _____
QA Specialist _____ LOCATION _____
(Print Name)

_____ Date and time correct.
_____ Alcohol-free subject test result 0._____ AC.
_____ Proper sample recognition system.
_____ Test Refused" prints.
_____ Controls, displays, and printer worked correctly during the above quality assurance procedures.

CALIBRATION OF INTOXIMETER RBT IV

( ) 1. Have a standard alcohol source of known value ready. This may be a simulator (at 34°C ± 0.2°C) or a dry gas alcohol standard.
Standard value: 0._____ AC.
( ) 2. Remove the Alco-Sensor IV battery cover.
( ) 3. Turn on RBT IV. Press START. Insert mouthpiece
( ) 4. Device temperature registers between 23°C and 27°C.
( ) 5. After the blank is taken and while .000 is displayed, depress button 3 until a number is displayed. SET is displayed when button 3 is released.
( ) 6. Press the SET button. Raise or lower the number now displayed (using buttons 1 or 2) to match the value of the standard being used. Press button 3 when correct. CAL will be displayed and the RBT IV will display PROCEED WITH TEST.
( ) 7. Attach the alcohol standard to the mouthpiece and introduce gas into the Alco-Sensor IV. At 5 seconds and while gas is still flowing, press the MANUAL button.
( ) 8. Press the SET button. Eject the mouthpiece. Remove the test record when printout is complete.
( ) 9. Run a calibration check on the Standard Calibration Check Procedure.

COMMENTS _____
_____
_____

SIGNATURE _____

DHS/DSLS/Form C140

Historical Note
Exhibit Y adopted effective February 12, 1996 (Supp. 96-1).

ARTICLE 5. TESTS FOR METABOLIC DISORDERS AND HEMOGLOBINOPATHIES

R9-14-501. Definitions

In this Article, unless context otherwise requires:

1. "Biotinidase deficiency" means a congenital metabolic disorder characterized by abnormal biotinidase production which causes mental retardation if not treated early in life.
2. "Committee" means the newborn screening program committee appointed by the Director.
3. "Congenital hypothyroidism" means a metabolic disorder characterized by a deficiency of thyroid hormone (thyroxin) production which causes mental and physical retardation if not treated early in life.
4. "Department" means the Department of Health Services.
5. "Director" means the Director of the Department of Health Services.
6. "Galactosemia" means a congenital metabolic disorder characterized by abnormal galactose metabolism which causes mental retardation or death if not treated early in life.
7. "Health care facility" means any establishment, public or private, that provides facilities for obstetrical care and care to a newborn.
8. "Health care provider" means the physician, nurse practitioner, or licensed midwife caring for the newborn after delivery.
9. "Hemoglobinopathies" mean a group of inherited diseases characterized by an abnormality in the production and function of hemoglobin.

10. "Homocystinuria" means a congenital metabolic disorder characterized by abnormal methionine metabolism which causes mental retardation if not treated early in life.
11. "Initial screen" means laboratory procedures performed on the first acceptable specimen of blood to detect the presence of metabolic disorder and/or a hemoglobinopathy.
12. "Maple syrup urine disease" or "M.S.U.D." means a congenital metabolic disorder of branch chain amino acid metabolism which causes mental retardation or death if not treated early in life.
13. "Newborn" means an infant 30 days of age and under for whom a certificate of live birth is required by A.R.S. § 36-322 to be filed with the Department.
14. "Newborn screening laboratory" means a laboratory with which the Department contracts to conduct testing of the newborn screening specimens.
15. "Newborn Screening Program" means the administrative and coordination program of the Department, the newborn screening laboratory, and the follow-up services provided by designated clinical service providers.
16. "Newborn Screening Tests" means the laboratory procedures performed on a sample of blood to detect the presence of metabolic disorders and hemoglobinopathies as stated in R9-14-502.
17. "Phenylketonuria or P.K.U." means a congenital metabolic disorder characterized by abnormal phenylalanine metabolism which causes mental retardation if not treated early in life.
18. "Repeat test" means laboratory procedures performed on a specimen of blood to verify an abnormal result reported on the initial or second screen.
19. "Second screen" means laboratory procedures performed on a second specimen of blood if the initial specimen was collected within 24 hours of birth.
20. "Sickle cell diseases" mean a group of hemoglobinopathies characterized by the distortion of the red blood cells which may lead to septicemia or death in infancy if not adequately treated.
21. "Specimen collection kit" means a filter paper kit that is either licensed or approved by the Food and Drug Administration and has been approved by the newborn screening laboratory.
22. "To order" means to direct appropriate personnel to obtain specimens and send them for laboratory tests.
23. "Unsatisfactory specimen" means any blood sample rejected by the Newborn Screening Laboratory, prior to testing, that could provide unreliable, misleading, or clinically inaccurate results.
24. "Working day" means 8:00 a.m. to 5:00 p.m. Monday through Friday excluding state holidays.

Historical Note

Adopted effective November 2, 1979 (Supp. 79-6). Section R9-14-501 renumbered from R9-14-512 and amended effective June 14, 1990 (Supp. 90-2). Amended by emergency action effective October 27, 1994, pursuant to A.R.S. § 41-1026, valid for 90 days (Supp. 94-4). Amended again by emergency action effective January 25, 1995, valid for 180 days (Supp. 95-1). Amended effective July 10, 1995 (Supp. 95-3).

R9-14-502. Testing of Newborns

A. The attending physician or other person required to make a report on the birth of a newborn born in Arizona shall order or cause to be ordered the following tests for metabolic disorders and hemoglobinopathies: phenylketonuria, galactosemia, congenital hypothyroidism, biotinidase deficiency, homocystinuria, maple syrup urine disease, sickle cell disease, and other hemoglobinopathies. If a parent or guardian refuses the newborn screening tests, such refusal shall be documented in writing and shall be part of the newborn's medical record with a copy sent to the Newborn Screening Program.

B. If the initial screening sample was collected within 24 hours of birth, the responsible person shall inform the newborn's parents or guardian that a second screen for metabolic disorders shall be performed between 3 and 7 days of age.

C. The specimens for testing shall be sent, no later than 24 hours or the next working day after being obtained, to the newborn screening laboratory.

D. The results from all abnormal newborn tests for metabolic and/or hemoglobin disorders shall be reported to the Newborn Screening Program, which shall notify the health care provider.

E. The results from any confirmatory testing, ordered in response to an abnormal newborn screen, shall be reported to the Newborn Screening Program.

Historical Note

Adopted effective November 2, 1979 (Supp. 79-6). Section R9-14-502 renumbered from R9-14-513 and amended effective June 14, 1990 (Supp. 90-2). Amended by emergency action effective October 27, 1994, pursuant to A.R.S. § 41-1026, valid for 90 days (Supp. 94-4). Amended again by emergency action effective January 25, 1995, valid for 180 days (Supp. 95-1). Amended effective July 10, 1995 (Supp. 95-3).

R9-14-503. Persons and Health Care Facilities Responsible for Tests

A. Births occurring in a health care facility.
1. The health care provider shall order the tests or shall ensure that the tests are ordered.
2. The administrator in charge of the health care facility or the administrator's designee shall ensure that specimens are collected on all newborns born or transferred to that health care facility. The newborn's medical record shall indicate that the tests were ordered or that the parent or guardian refused the test.
3. The specimens for these tests shall be obtained when the newborn is three days of age or immediately prior to the time of discharge from the health care facility, whichever is earlier.
4. The specimen shall be capillary or venous blood and shall be collected utilizing a specimen collection kit obtained from the newborn screening laboratory. Cord blood shall not be accepted.
5. The person in charge of the health care facility or the designated representative shall ensure that all information requested on the form within the specimen collection kit is completed.
6. If the newborn is transferred to another health care facility before 3 days of age, the receiving health care facility shall be responsible for obtaining the specimen for newborn screening.
7. If the initial screening specimen for any newborn was collected within 24 hours of birth, the health care facility and the health care provider shall inform the newborn's parents that a second screen is required at 3 to 7 days of age.

B. Births occurring outside a health care facility.
1. The health care provider shall order the tests or shall ensure that the tests are ordered.

2. If the initial screening sample for any newborn was collected within 24 hours of birth, the health care provider shall notify the newborn's parents that a second screen is required between 3 and 7 days of age.
3. If the birth is not attended by a health care provider with the authority to order the test, the person required by A.R.S. § 36-322(E)(3) or (4) to report the birth shall notify the local or state registrar when the certificate of live birth is filed. The registrar shall notify the health officer in the county where the newborn's parents are expected to reside. The health officer shall ensure collection of a specimen within three days from the time of notification of the birth.
4. The specimen shall be capillary or venous blood and shall be collected utilizing a specimen collection kit obtained from the newborn screening laboratory. Cord blood shall not be accepted.

Historical Note
Adopted effective November 2, 1979 (Supp. 79-6). Section R9-14-503 renumbered from R9-14-514 and amended effective June 14, 1990 (Supp. 90-2). Amended effective July 10, 1995 (Supp. 95-3).

R9-14-504. Parent or Guardian Education

A. The health care provider or designee shall inform the newborn's parent or guardian of the reasons for the tests.

B. The health care facility shall be responsible for distributing written educational materials on newborn screening provided by the Department.

Historical Note
Adopted effective November 2, 1979 (Supp. 79-6). Section R9-14-504 renumbered from R9-14-515 and amended effective June 14, 1990 (Supp. 90-2). Amended effective July 10, 1995 (Supp. 95-3).

R9-14-505. Screening Fees; Collection

The following fees shall be charged for newborn screening:
1. The fee shall be $20.00 for an initial test.
2. The fee shall be $15.00 for a second screen.

B. There shall be no fee charged for a repeat test or for an unsatisfactory specimen.

Historical Note
Adopted by emergency action effective October 27, 1994, pursuant to A.R.S. § 41-1026, valid for 90 days (Supp. 94-4). Adopted again by emergency action effective January 25, 1995, valid for 180 days (Supp. 95-1). Adopted effective July 10, 1995 (Supp. 95-3).

R9-14-506. Reserved

R9-14-507. Reserved

R9-14-508. Reserved

R9-14-509. Reserved

R9-14-510. Reserved

R9-14-511. Repealed

Historical Note
Adopted effective November 2, 1979 (Supp. 79-6). Repealed effective June 14, 1990 (Supp. 90-2)

R9-14-512. Renumbered

Historical Note
Adopted effective November 2, 1979 (Supp. 79-6). Section R9-14-512 renumbered to R9-14-501 effective June 14, 1990 (Supp. 90-2).

R9-14-513. Renumbered

Historical Note
Adopted effective November 2, 1979 (Supp. 79-6). Section R9-14-512 renumbered to R9-14-502 effective June 14, 1990 (Supp. 90-2)

R9-14-514. Renumbered

Historical Note
Adopted effective November 2, 1979 (Supp. 79-6). Section R9-14-514 renumbered to R9-14-503 effective June 14, 1990 (Supp. 90-2).

R9-14-515. Renumbered

Historical Note
Adopted effective November 2, 1979 (Supp. 79-6). Section R9-14-515 renumbered to R9-14-504 effective June 14, 1990 (Supp. 90-2).

ARTICLE 6. LICENSING OF ENVIRONMENTAL LABORATORIES

R9-14-601. Definitions

Words and phrases defined in A.R.S. §§ 36-495 have the same meaning when used in these rules. In this Article, unless otherwise specified:
1. "ADEQ" means the Arizona Department of Environmental Quality.
2. "Approved method" means an analytical test method which is recognized by the Department as acceptable to test for the presence of the particular contaminant.
3. "Arizona Permit System for Aquifer Protection" means the permit system specified in A.R.S. §§ 49-241 through 49-251.
4. "Arizona Permit System for Reuse of Wastewater" means the permit system specified in A.R.S. §§ 49-104 and 49-250.
5. "Blind proficiency evaluation audit" means that the Department submits a series of proficiency evaluation samples to a laboratory in such a manner that the laboratory is unaware that it is testing a proficiency evaluation sample.
6. "Categories" of laboratory testing means drinking water, wastewater, hazardous waste, or air.
7. "Clean Air Act" means 42 U.S.C.A. 7401 - 7642.
8. "Clean Water Act" means 33 U.S.C.A. 1251 - 1376.
9. "Comprehensive Environmental Response, Compensation and Liability Act" means 42 U.S.C.A. 9601-9657, commonly referred to as the Superfund Act.
10. "Contiguous grounds" means real property which can be enclosed by a single unbroken boundary line which does not enclose property owned or leased by others.
11. "Effluent" means an outflow, as of a stream which flows out of a facility.
12. "Environmental water laboratory" means a laboratory that holds a valid license issued by the Department prior to the effective date of this Article.
13. "EPA" means the United States Environmental Protection Agency.
14. "Federal Insecticide Fungicide and Rodenticide Act" means 7 U.S.C.A. 136 - 136y.
15. "Intercomparison studies" means the proficiency evaluation service for radiochemical samples established by EPA's Environmental Monitoring Systems Laboratory.
16. "Licensure" means the approval by the Department of a laboratory to perform compliance testing for environmental monitoring programs, categories of laboratory testing,

parameters of laboratory testing and approved methods of laboratory testing as defined in A.R.S. § 36-495.03 through A.R.S. § 36-495.16 and this Article.

17. "Parameter" means 1 of a set of chemical, physical, radiochemical, microbiological, or biological properties whose value determines the characteristics of an environmental sample.
18. "Proficiency evaluation audit" means an audit conducted by a service on a series of samples submitted to a laboratory for use in evaluating the laboratory's ability to correctly analyze compliance testing samples.
19. "Proficiency evaluation service" means the Department, EPA, or an independent service acceptable to the Department which provides proficiency evaluation audit samples and evaluates the results of the proficiency evaluation audit.
20. "Principal State Laboratory System" means the system which includes the Department, Division of State Laboratory Services, and the Radiation Regulatory Agency Laboratory, which are certified by EPA.
21. "Radiation assessment proficiency evaluation audit" means any proficiency evaluation audit required by EPA under the Safe Drinking Water Act for radiochemistry testing.
22. "Resource Conservation and Recovery Act" means 42 U.S.C.A. 6921 - 6939B.
23. "Safe Drinking Water Act" means 42 U.S.C.A. 300f-300j-11.
24. "Single Method" means the approved method licensure fee for any single method listed in that subsection.
25. "U.S.C.A." means *United States Code Annotated*.
26. "Water pollution proficiency evaluation audit" means any proficiency evaluation audit established by the EPA under the Clean Water Act.
27. "Water supply study audit" means any proficiency evaluation audit required by the EPA under the Safe Drinking Water Act.

Historical Note

Adopted effective August 16, 1985 (Supp. 85-4). Former Section R9-14-601 repealed, new Section R9-14-601 adopted effective December 20, 1991 (Supp. 91-4). Amended effective June 20, 1997 (Supp. 97-2).

R9-14-602. License Applicability

A. This Article shall not apply to compliance testing of parameters as outlined in A.R.S §§ 36-495.02.A.3.

B. This Article shall not apply to laboratory compliance testing which is performed pursuant to the Federal Insecticide Fungicide and Rodenticide Act.

Historical Note

Adopted effective August 16, 1985 (Supp. 85-4). Former Section R9-14-602 repealed, new Section R9-14-602 adopted effective December 20, 1991 (Supp. 91-4). Amended effective June 20, 1997 (Supp. 97-2).

R9-14-603. Initial Licensure Process

A. To obtain a license the laboratory shall file a complete application on a form provided by the Department pursuant to A.R.S. § 36-495.03 (A) and (B), and submit payment of all applicable fees to the Department pursuant to R9-14-606.

B. Multiple laboratories located on contiguous grounds and under the same ownership may be licensed under a single license.

C. Multiple laboratories, including mobile laboratories located on non-contiguous grounds and under the same ownership may be licensed independently or under a single license at the owner's discretion. If the laboratory chooses the single license option, each nonmobile laboratory shall be located within Arizona and each mobile laboratory shall maintain Arizona vehicle registration.

D. An application for licensure shall be made for any of the approved methods contained in R9-14-608 and R9-14-609 through R9-14-612 for compliance testing required by ADEQ; the Clean Air Act; the Clean Water Act; the Comprehensive Environmental Response, Compensation and Liability Act; the Resource Conservation and Recovery Act; the Safe Drinking Water Act; or the Toxic Substance Control Act.

E. The Department shall determine if the application is complete and mail notification to the applicant with a detailed list of deficiencies if incomplete within 3 weeks from receipt of the application and fees. An application is not complete without payment of all applicable fees. Upon receipt of a complete application, the Department shall schedule a laboratory inspection**,** proficiency evaluation audit, or both, no longer than 1 month later for an in-state lab and 2 months later for an out-of-state lab. The Department and applicant may mutually agree to extend the inspection date.

F. The Department may grant a temporary license for all sample matrices except drinking water, to an out-of-state laboratory, before an on-site inspection occurs, provided:

1. The laboratory has submitted a complete application,
2. The laboratory has provided successful proficiency evaluation results from current EPA studies or 3rd party proficiency evaluation audits, and
3. The laboratory has provided current certification information for comparable testing from another state certification program.

G. The Department shall provide the laboratory director with a written report of findings of compliance with A.R.S. Title 36, Chapter 4.3, Article 1 and this Article, within 6 weeks from the completion of any inspection, investigation, or proficiency evaluation audit.

H. If the laboratory is not in compliance:

1. Within 3 weeks from receipt of a report of noncompliance, the laboratory shall submit a written corrective action plan acceptable to the Department with corrective action and completion dates no longer than 4 months from the date the laboratory receives the written report of noncompliance.
2. Within 6 weeks of receipt of the laboratory's plan of corrective action, the Department shall provide the laboratory with a written approval or disapproval.
3. If the laboratory's plan of corrective action is disapproved by the Department, the laboratory shall submit a new corrective action plan for the items which the Department has disapproved within 3 weeks from receipt of the Department's written disapproval.
4. Within 3 weeks of receipt of the laboratory's revised corrective action plan, the Department shall provide the laboratory with a written approval or disapproval of the revised plan.

I. The Department will send written notification of approval or denial of an application within 9 months for an in-state lab and 10 months for an out-of-state lab. Denials shall set forth the reasons for denial and all other information required under A.R.S. § 41-1076.

J. This Section shall apply to a laboratory not currently licensed in Arizona until either of the following occurs:

1. The laboratory owner or operator is issued a laboratory license pursuant to this Article, or
2. The laboratory owner or operator is notified of the Department's intent to deny a laboratory license.

K. Notification by the Department of issuance or denial of a license shall not exceed 9 months for in-state labs, and 10 months for out-of-state labs from the date that the Department determined that the application was complete. Completeness review is 3 weeks. The overall time frame is 9 months and 3 weeks for in-state labs and 10 months and 3 weeks for out-of-state labs.

L. For the purpose of computing time frames in this Section intermediate Saturdays, Sundays, and legal holidays shall be included in the computation. The last day of the time period will be included unless it is a Saturday, Sunday, or legal holiday.

Historical Note

Adopted effective August 16, 1985 (Supp. 85-4). Former Section R9-14-603 repealed, new Section R9-14-603 adopted effective December 20, 1991 (Supp. 91-4). Section citation corrected in preceding historical note; Section amended effective June 20, 1997 (Supp. 97-2).

R9-14-604. Licensure Renewal Process

A. At least 1 month prior to the expiration of its current license, a laboratory must submit to the Department, a complete application and payment of all applicable fees prescribed in R9-14-606.

B. The Department shall notify the laboratory director of any deficiency in the application and payment of fees within 3 weeks from the receipt of the application and fees. If the application is complete and proper fees are submitted, the Department shall renew a laboratory license, unless the Director determines pursuant to A.R.S. § 36-495.09 that grounds exist to deny the license.

C. The Department may grant a temporary license to a laboratory with an existing laboratory license, if the laboratory is moving to a new location. The Department shall not grant the temporary license to such laboratories if the owner or director is also changed.

D. The Department may conduct a laboratory inspection or proficiency evaluation audit, or both, at any time during the licensure period.

E. The Department shall provide the laboratory director with a written report of findings within 6 weeks from the completion of any inspection, investigation, or proficiency evaluation audit.

F. A licensed laboratory that cannot demonstrate compliance with this Article, shall submit to the Department within 6 weeks from the date the laboratory receives the written report of findings, a written plan to correct deficiencies listed in the written report of findings with corrective action and completion dates acceptable to the Department.

G. The Department shall provide the laboratory with a written response within 6 weeks of receipt of the laboratory's plan of corrective action to the Department's written report of findings.

Historical Note

Adopted effective August 16, 1985 (Supp. 85-4). Former Section R9-14-604 repealed, new Section R9-14-604 adopted effective December 20, 1991 (Supp. 91-4). Section citation corrected in preceding historical note; former Section R9-14-604 renumbered to R9-14-605; new Section adopted effective June 20, 1997 (Supp. 97-2).

R9-14-605. Provisional Licensure

A. The Department may issue a provisional license when its investigation, inspection, or proficiency evaluation audit identifies deficiencies, but the number and nature of deficiencies do not pose a risk to public health, safety, or the environment.

B. The Department may issue a provisional license for any of the following reasons:

1. The laboratory does not adhere to the applicable references in R9-14-608 or the requirements for facilities, equipment, reagents, quality control practices, or approved methods appropriate to the sample matrix as listed in R9-14-609 through R9-14-612;
2. The laboratory fails to participate in a proficiency evaluation audit and submit results within the acceptance limits or the time frames established by the proficiency evaluation service;
3. Two consecutive proficiency evaluation audit reports have the same parameter deemed outside acceptance limits by a proficiency evaluation service; or
4. The laboratory fails to submit a written corrective action report to the Department within 6 weeks of the receipt of proficiency evaluation audit results that are deemed outside acceptable limits.

C. The Department shall issue an amended certified list of parameters for the provisional license.

D. The licensee shall return its license to the Department within 10 working days from the date of receipt of written notification that the Department issued a provisional license.

E. A provisional license shall be valid for a set period established by the Department, not to exceed the expiration date of the laboratory's suspended license.

F. A laboratory with a provisional license may renew its license provided that it applies for renewal at least 6 weeks prior to the expiration of its provisional license. At such time, the Department shall issue to the laboratory a renewed license, unless the Director determines pursuant to A.R.S. § 36-495.09 that grounds exist to revoke the license.

Historical Note

Adopted effective August 16, 1985 (Supp. 85-4). Former Section R9-14-605 repealed, new Section R9-14-605 adopted effective December 20, 1991 (Supp. 91-4). Section citation corrected in preceding historical note; former Section R9-14-605 renumbered to R9-14-606; new Section R9-14-605 renumbered from R9-14-604 and amended effective June 20, 1997 (Supp. 97-2).

R9-14-606. Licensure fees

A. Each laboratory applying for a license shall pay to the Department, at the time of application, a nonrefundable application fee except as required by A.R.S. § 41-1077, in U.S. dollars, dependent upon the following laboratory license classifications:

1. Level I - A license for compliance testing is limited to 1 to 9 total parameters in any combination of categories of laboratory testing. $1,000.00
2. Level II - A license for compliance testing is limited to 10 to 17 total parameters in any combination of categories of laboratory testing. $1,270.00
3. Level III - A license for compliance testing for greater than 17 total parameters in any combination of categories of laboratory testing. $1,400.00

B. Multiple laboratories applying under the single license option shall pay to the Department, at the time of application, a nonrefundable application fee, except as required by A.R.S. § 41-1077, for each noncontiguous laboratory, as outlined in R9-14-603, dependent upon the following laboratory license classifications:

1. Level I - $860.00
2. Level II - $1,130.00
3. Level III - $1,270.00

C. Concurrently with the licensure application fee, the applicant shall pay a nonrefundable fee, except as required by A.R.S. § 41-1077, for licensure of approved methods and associated instrumentation calculated by the Department as follows:

1. Microbiology Testing Fees	
a) Total coliform:	
Most Probable Number	$136.00
Membrane filtration	136.00
MMO-MUG (Colilert or Colisure only)	91.00
Presence-Absence	136.00
b) Fecal coliform:	
Most Probable Number	136.00
Membrane filtration	136.00
c) Fecal streptococcus:	
Most Probable Number	136.00
Membrane filtration	136.00
Salmonella	136.00
Heterotrophic plate count	91.00
Any 1 approved method in each group for total coliform, fecal coliform, fecal streptococcus, Salmonella and heterotrophic plate count.	408.00
Any combination of approved methods for total coliform, fecal coliform, fecal streptococcus, Salmonella and heterotrophic plate count.	725.00
Viruses	227.00
Parasites	227.00
2. Bioassay	
Any combination of methods for estimating the chronic and acute toxicity of effluents and waters to fresh waterorganisms.	$544.00
3. Demand	
Biochemical Oxygen Demand	$91.00
Chemical Oxygen Demand	91.00
4. Inorganic Chemistry - Metals	
a) Flame atomic absorption (FAA) approved methods.	
Each metal for which the laboratory applies using any single FAA approved method from any single approved method reference.	$15.00 each, up to a maximum of $295.00
Each metal for which the laboratory applies using any combination of FAA approved methods from any combination of approved method references.	$24.00 each, up to a maximum of $468.00
b) Electrothermal graphite furnace atomic absorption (GFAA) approved methods.	
Each metal for which the laboratory applies using any single GFAA approved method from any single approved method reference.	$15.00 each, up to a maximum of $272.00
Each metal for which the laboratory applies using any combination of GFAA approved methods from any combination of approved method references.	$24.00 each, up to a maximum of $435.00
c) Inductively Coupled Plasma (ICP) emission spectrometer approved methods.	
Each metal for which the laboratory applies using any single ICP approved method from any single approved method reference.	$12.00 each, up to a maximum of $260.00
Each metal for which the laboratory applies using any combination of ICP approved methods from any combination of approved method references.	$18.00 each, up to a maximum of $390.00
d) Inductively Coupled Plasma/Mass Spectrometer (ICP/MS) approved methods.	
Each metal for which the laboratory applies using any ICP/MS approved method from any approved method reference.	$18.00 each, up to a maximum of $390.00
e) Colorimetric metal testing approved methods.	
Each colorimetric approved method for which the laboratory applies.	$45.00
f) Mercury cold vapor approved methods.	
Any single mercury cold vapor approved method from any single approved method reference for which the laboratory applies.	$91.00
Any combination of mercury cold vapor approved methods from any combination of approved method references for which the laboratory applies.	$136.00
g) Metals by hydride generation approved methods.	
Each hydride metal for any approved methodfrom any approved method reference for which the laboratory applies.	$45.00 each, up to a maximum of $68.00

5. Inorganic Chemistry - Nonmetals		
a) Nonmetals Group IA		
Total Alkalinity		$23.00
Chloride		23.00
Chlorine		23.00
Chlorine dioxide		23.00
Color		23.00
Hardness (as CaCO3)		23.00
Hydrogen ion (pH)		23.00
Ozone		23.00
Specific conductance		23.00
Total Dissolved Solids (Filterable Residue)		23.00
Turbidity		23.00
b) Nonmetals Group IB		
Nitrate		$45.00
Sulfate		45.00
Fluoride		45.00
Sodium Azide		45.00
Sodium/Potassium Perchlorate		45.00
c) Maximum for any combination of Nonmetals Group IA and IB for the 1st approved method for which the laboratory applies.		$255.00
d) Each additional Nonmetals Group IA approved method for which the laboratory applies.		$11.00
e) Each additional Nonmetals Group IB approved method for which the laboratory applies.		$23.00
f) Nonmetals Group IIA		
Acidity		$23.00
Total Hardness		23.00
Surfactants		23.00
Total Residue		23.00
Nonfilterable Residue		23.00
Settleable Residue		23.00
Volatile Residue		23.00
g) Nonmetals Group IIB		
Ammonia		$45.00
Bromide		45.00
Total Kjeldahl Nitrogen		45.00
Nitrite		45.00
Orthophosphate		45.00
Total Phosphorus		45.00
h) Maximum for any combination of Nonmetals Group IIA and IIB for the 1st approved method for which the laboratory applies.		340.00
i) Each additional Nonmetals Group IIA approved method for which the laboratory applies.		$11.00
j) Each additional Nonmetals Group IIB approved method for which the laboratory applies.		$23.00
k) Ion chromatograph approved methods.		
Each ion for which the laboratory applies using any IC approved method from any approved method reference.		$20.00 each, up to a maximum of $200.00
6. Major Analytical Chemistry Instruments		
Each Gas Chromatograph (GC) instrument.		$45.00
Each Gas Chromatograph/Mass Spectrometer (GC/MS) instrument.		91.00
Each Atomic Absorption Spectrometer instrument.		45.00
Each Inductively Coupled Plasma Atomic Emission Spectrometer instrument.		45.00
Each Inductively Coupled Plasma Atomic Emission Spectrometer/Mass Spectrometer Instrument.		91.00
Each High Performance Liquid Chromatograph instrument.		45.00
Each High Performance Liquid Chromatograph/Mass Spectrometer instrument.		91.00
Each Ion Chromatograph instrument.		45.00
Each Total Organic Halide (TOX) instrument.		45.00
Each Transmission Electron Microscope (TEM).		182.00
7. Volatile Organic Chemistry		
Purgeable Organic GC and GC/MS approved methods.	Single Method	Combination
Volatile Organics by GC by EPA Methods 502.2, 8021A	$91.00	$136.00
Purgeable Halocarbons by EPA Methods 601 and 8010B	45.00	68.00

Total Trihalomethanes (TTHM) 502.2, 524.2, 551	45.00	91.00
Maximum Trihalomethane Potential (MTP) 510.1		45.00
Purgeable Aromatics by EPA Methods 602, 8015A, 8015M, 8020A	45.00	91.00
Fuel Class Hydrocarbons by BLS Method 191	45.00	
Halogenated and Aromatic Volatiles by EPA Method 8021A	91.00	
Acrolein, Acrylonitrile, Acetonitrile by EPA Methods 603, 8031, 8032, 8033, 8316	45.00	68.00
Purgeables by GC/MS by EPA Methods 524.2, 624, 1624, 8260A	91.00	181.00

8. Semivolatile Organic Chemistry

Semivolatile organic GC approved methods	Single Method	Combination
Aniline and Derivatives by EPA Method 8131	$69.00	
Benzidines by EPA Method 605	45.00	
Benzidines and Nitrogen Pesticides by EPA 553	69.00	
Bis(2-chloroethyl)ether Hydrolysis Products by EPA 8430	69.00	
Carbamates/Urea Pesticides by EPA Methods 531.1, 632, 8318	69.00	102.00
Carbonyl Compounds by EPA 8315	69.00	
Chlorinated Herbicides by EPA Methods 515.2, 555, 8151, Standard Methods 6640-B, ASTM D-3478-85	69.00	102.00
Chlorinated Hydrocarbons by EPA Methods 612, 8121	69.00	102.00
1,2-Dibromoethane and 1,2-Dibromo-3-Chloropropane by EPA Methods 504.1, 551, 8011, BLS Method 127	69.00	102.00
Diquat and Paraquat by EPA Method 549.1	69.00	
Endothall by EPA Method 548.1	69.00	
Glyphosate by EPA Method 547, 6651	69.00	102.00
Haloacetic Acetic Acids by EPA Method 552 and 552.1	69.00	102.00
Haloethers by EPA Methods 611, 8111	69.00	102.00
Nitroaromatics and Cyclic Ketones by EPA Methods 609, 8091, 8330	69.00	102.00
Nitroglycerine by EPA 8332	69.00	
Nitrosamines by EPA Methods 607, 8070, 8330	69.00	102.00
Nonvolatiles by HPLC/MS by EPA 8321, 8325	91.00	136.00
Organochlorine Pesticides/Polychlorinated Biphenyls by EPA Methods 505, 508, 508.1, 608, 8081, 8082 Standard Method 6630C, ASTM Method D3086-85, EPA-600/4-81-045	91.00	136.00
Organophosphorus and Nitrogen Pesticides by EPA Methods 507, 614, 8141A	69.00	102.00
Phenols by EPA Methods 604, 8041A	69.00	102.00
Polynuclear Aromatic Hydrocarbons by EPA Methods 550, 550.1, 610, 8100, 8310	69.00	102.00
Polynuclear Aromatic Hydrocarbons by EPA Method 8310	69.00	
Phthalate Esters by EPA Methods, 606, 8061, 506	69.00	102.00
Semivolatile organic GC/MS approved methods by EPA Methods 525.2, 625, 1625, 8270B	91.00	182.00
Semivolatile organics GC/FT-IR by EPA 8410	69.00	
Tetrazine by EPA 8331	69.00	
Triazine Pesticides by EPA Method 619	69.00	
Dioxin and Furans by EPA Methods 1613, 613, 8280, 8290,	272.00	362.00
Director approved GC methods	69.00	
Director approved GC/MS methods	91.00	

9. Radiochemicals

Fee for radiochemistry testing	$270.00
Each radioisotope counting instrument	45.00
Gross Alpha Activity	91.00
Gross Beta Activity	91.00
Radium-226	91.00
Radium-228	91.00
Cesium-134	91.00
Iodine-131	91.00
Polonium-210	91.00
Radon-222	91.00
Strontium-89	91.00
Strontium-90	91.00
Tritium	91.00
Uranium	91.00
Photon Emitters, each method	91.00
Each radiochemical approved method when the laboratory applies for 5 or more.	73.00

10. Hazardous Characteristic Testing Approved Methods

Corrosivity toward steel	$38.00

Ignitability	38.00
Reactivity	38.00
Extraction Procedure Toxicity Characteristic*	91.00
Toxicity Characteristic Leaching Procedure*	181.00
Synthetic Characteristic Leaching Procedure*	181.00
* (The fee for these procedures are for the sample extraction and leaching processes only.)	
11. Miscellaneous Compliance Testing	
Total Organic Carbon	$45.00
Total Organic Halides	45.00
Purgeable Organic Halides	68.00
Extractable Organic Halides	68.00
Ethylene Glycol	91.00
Total Petroleum Hydrocarbon	91.00
Oil and Grease	45.00
Cyanide; total, direct, and amenable to chlorination	91.00
Total Phenols	91.00
Lead in paint	23.00
Magnesium - gravimetric	23.00
Sulfide	45.00
Sulfite	45.00
Silica	45.00
Bulk Asbestos Identification	136.00
White Phosphorous	69.00
Immunoassay Tests (each)	45.00
Compatability Test for Wastes and Membrane Liners	20.00
Cation-Exchange Capacity of Soil	20.00
Director approved methods	20.00
Asbestos fiber counting by:	
Light microscopy	136.00
Electron microscopy	227.00
Electron Microscopy with X-Ray Diffraction	300.00
12. Ambient Air Compliance Testing Approved Methods	
Carbon Monoxide	$181.00
Hydrocarbons	181.00
Lead	181.00
Nitrogen Dioxide	181.00
Ozone	181.00
Particulate Matter	181.00
Sulfur Oxides	181.00
Maximum for ambient air testing.	952.00
13. Air - Stationary Sources and Stack Testing Approved Methods	
Carbon Dioxide/Oxygen/Excess Air	$181.00
Carbon Monoxide	181.00
Carbonyl Sulfide/Carbon Dioxide	181.00
Fluoride	181.00
Gaseous Organic Compounds	181.00
Hydrogen Sulfide	181.00
Inorganic Lead	181.00
Moisture Content	181.00
Nitrogen Oxide	181.00
Particulate Emissions:	
Asphalt Processing	91.00
Fiberglass Insulation	91.00
Nonsulfate	91.00
Nonsulfuric Acid	91.00
Pressure Filters	91.00
Stationary Sources	91.00
Sulfur Dioxide	91.00
Wood Heaters	91.00
Particulate emissions maximum	544.00
Sulfur and Total Reduced Sulfur	181.00
Sulfur Dioxide	181.00
Sulfuric Acid Mist	181.00
Volatile Matter/Density/Solids/Water	181.00
Vapor Tightness - Gasoline Delivery Tank	181.00
Volatile Organic Compounds	181.00

Wood Heaters Certification and Burn Rates	181.00
Stationary Sources and Stack Testing maximum	2,720.00
14. Arizona Emission Test Approved Methods	
Particulate Emissions:	
Sulfuric Acid Mist/ Sulfur Oxides	$181.00
Dry Matter	181.00
15. Hazardous Air Pollutant Approved Methods For National Emission Standards	
Arsenic	$181.00
Beryllium	181.00
Mercury	181.00
Polonium-210	181.00
Vinyl Chloride	181.00
Maximum for hazardous air pollutants	680.00

D. The laboratory shall pay a nonrefundable, except as required by A.R.S. §41-1077, handling fee of $78.00 for each proficiency evaluation audit and the actual cost for proficiency evaluation audit materials, if applicable.

E. Except for the appointment of an acting laboratory director, a change in the laboratory name, directorship, or ownership a laboratory which requests an amendment or modification to its license before its expiration date**,** shall pay all applicable licensure fees. Laboratories shall have 3 free modifications to delete parameters during a licensure period. Thereafter, each additional deletion shall be charged at a rate of $10.00 per parameter for processing.

F. Each out-of-state licensed laboratory shall pay an annual fee of $75.00 if the laboratory chooses to receive technical updates from the Department by FAX.

Historical Note

Adopted effective August 16, 1985 (Supp. 85-4). Former Section R9-14-606 repealed, new Section R9-14-606 adopted effective December 20, 1991 (Supp. 91-4). Section citation corrected in preceding historical note; former Section R9-14-606 renumbered to R9-14-607; new Section R9-14-606 renumbered from R9-14-605 and amended effective June 20, 1997 (Supp. 97-2).

R9-14-607. Proficiency Evaluation

A. Each laboratory shall demonstrate proficiency as determined by the Department through proficiency evaluation audits provided by the Principal State Laboratory System, if available, or a proficiency evaluation service provider approved by the Department. The laboratory shall analyze and report proficiency evaluation audit samples for the testing program, category of testing, parameter, and approved methods for which an initial license or renewal license has been requested. Proficiency evaluation parameters reported by the laboratory for subsections (B) through (G) of this Section shall be within acceptance limits established by the proficiency evaluation service or in addition for subsection (B) as required by 40 CFR §§ 141.24, f.17.

B. To maintain licensure for the approved methods listed for chemistry in R9-14-609, the laboratory shall demonstrate continued proficiency through audits provided by the EPA's water supply study (WS) audit program, the Principal State Laboratory System proficiency evaluation audit program, if available, or a proficiency evaluation service accepted by the Department.

C. To maintain licensure for the approved methods listed for chemistry in R9-14-610 and R9-14-611, the laboratory shall demonstrate continued proficiency through audits provided by the EPA's water pollution (WP) proficiency evaluation audit program, the Principal State Laboratory System proficiency evaluation audit program, if available, or a proficiency evaluation service accepted by the Department.

D. To maintain licensure for the approved methods listed for microbiology in R9-14-609 through R9-14-611, the laboratory shall demonstrate continued proficiency through audits provided by the EPA's proficiency evaluation audit program, the Principal State Laboratory System proficiency evaluation audit program, if available, or a proficiency evaluation service accepted by the Department.

E. To maintain licensure for the approved methods listed for radiochemicals in R9-14-609 through R9-14-611, the laboratory shall demonstrate continued proficiency through audits provided by the EPA's radiation assessment proficiency evaluation audit and the Intercomparison studies audit programs.

F. To maintain licensure for the approved methods listed in R9-14-612, the laboratory shall demonstrate continued proficiency through audits provided by the EPA proficiency evaluation audit program, the Principal State Laboratory System proficiency evaluation audit program, if available, or from a proficiency evaluation service accepted by the Department.

G. The Department may submit blind audit samples to a licensed laboratory.

H. The laboratory shall test all proficiency evaluation audit samples within holding times required by the approved method for each of the audit parameters and report the results to the proficiency evaluation service. Principal State Laboratory System chemistry proficiency evaluation audit sample results shall be reported to the Department within 2 months from the time of receipt. Principal State Laboratory System microbiology proficiency evaluation audit sample results shall be reported to the Department within 2 weeks from the time of receipt.

I. The Department shall issue a report of Principal State Laboratory System proficiency evaluation audit findings to the laboratory within 2 months of the deadline date for results of the proficiency evaluation audit.

Historical Note

Adopted effective August 16, 1985 (Supp. 85-4). Former Section R9-14-607 repealed, new Section R9-14-607 adopted effective December 20, 1991 (Supp. 91-4). Section citation corrected in preceding historical note; former Section R9-14-607 renumbered to R9-14-608; new Section R9-14-607 renumbered from R9-14-606 and amended effective June 20, 1997 (Supp. 97-2).

R9-14-608. Approved Methods and References

A. All compliance samples shall be tested by approved methods and the results shall be validated by reference to the applicable quality assurance requirements listed in the following Key References; or in R9-14-609 through R9-14-612 as appropriate to the sample matrix, and/or as specifically required by ADEQ or EPA.

B. If approved methods are not available for a particular testing program, category of testing or parameter, and different meth-

ods are required by EPA or ADEQ, a lab may use another method if the method is approved by the Director.

1. For existing methods which are not approved methods under this Article, a laboratory may submit a petition to the Department requesting approval. The petition shall include reference to the EPA or ADEQ statute or rule which requires the use of the different method.
2. A laboratory may submit a petition to the Department requesting the approval of a recommended or locally developed procedure.
   a) The petition shall contain:
      i) Name, telephone number, and address of the person submitting the petition;
      ii) Identification of the pollutant or parameter for which approval of a recommended or locally developed procedure is being requested;
      iii) Written justification for using the recommended or locally developed procedure including a detailed description of the recommended or locally developed procedure, together with references to published or other studies confirming the general applicability of the recommended or locally developed procedure to the type of sample matrix for which its use is intended, and reference to the EPA or ADEQ requirement to use a recommended or locally developed procedure; and
      iv) Data which demonstrates the performance of the recommended or locally developed procedure in terms of accuracy, precision, reliability, ruggedness, ease of use and ability to achieve a detection limit appropriate for the proposed use of the method.
   b) The Department may approve a recommended or locally developed procedure if it determines that the criteria listed in R9-14-608(2)(a)(iv) have been demonstrated.
   c) The Department may require that the recommended or locally developed procedure be tested in parallel with a reference laboratory for precision and accuracy.

C. The following references identified by a capital letter under the heading "Key" contain the approved methods which are listed by parameter in R9-14-609 through R9-14-612. The following approved methods are incorporated by reference and on file with the Office of the Secretary of State and the Department. This incorporation by reference contains no future editions or amendments.

Key Reference

A "Methods for Chemical Analysis of Water and Wastes," EPA 600/4-79-020, EPA, Environmental Monitoring and Support Laboratory, Cincinnati, Ohio, revised March 1983.

A1 "Methods for the Determination of Metals in Environmental Samples-Supplement 1", EPA 600/R-94-111, Environmental Monitoring and Support Laboratory, Cincinnati, Ohio, May 1994.

A2 "Methods for the Determination of Inorganic Substances in Environmental Samples", EPA-600/R-93-100, August 1993.

B "Interim Radiochemical Methodology for Drinking Water," EPA 600/4-75-008, EPA, Environmental Monitoring and Support Laboratory, Cincinnati, Ohio, revised March 1976.

C "Standard Methods for the Examination of Water and Wastewater," APHA-AWWA-WPCF, Washington, D.C., 19th Edition, 1995.

C1 "Hach Handbook of Water Analysis," 1979, Hach Chemical Company, Loveland, CO 80537.

C2 "Iron, 1,10-Phenanthroline Method," Method 8008, 1980, Hach Chemical Company, P.O. Box 389, Loveland, CO 80537.

D "Methods for the Determination of Organic Compounds in Drinking Water," EPA/600/4-88/039, EPA, Environmental Monitoring and Support Laboratory, Cincinnati, Ohio, July 1991.

D1 "Methods for the Determination of Organic Compounds in Drinking Water, Supplement I,", EPA/600/4-90/020, EPA, Environmental Monitoring and Support Laboratory, Cincinnati, Ohio, July 1990.

D2 "Methods for the Determination of Organic Compounds in Drinking Water, Supplement II," EPA/600/R-92/129, EPA, Environmental Monitoring and Support Laboratory, Cincinnati, Ohio, August 1992.

D3 "Manual for the Certification of Laboratories Analyzing Drinking Water, 4th Edition," EPA 570/9-90/008, EPA, Environmental Monitoring and Support Laboratory, Cincinnati, Ohio, April 1990, and updated September 1992 and March 1997.

D4 "The Determination of the Maximum Total Trihalomethane Potential," Method 510.1, EMSL, EPA, Cincinnati, Ohio 45268.

D5 "Tetra-through Octa-Chlorinated Dioxins and Furans by Isotope-Dilution HRGC/HRMS", EPA-821-B-94-005, October 1994.

E "Appendix A To Part 136 - Methods for Organic Chemical Analysis of Municipal and Industrial Wastewater," 40 CFR Part 136, 1996.

E1 "Appendix C to Part 136 - Inductively Coupled Plasma - Atomic Emission Spectrometric Method for Trace Element Analysis of Water and Wastes, Method 200.7," 40 CFR Part 136, 1996.

F "Test Methods for Evaluating Solid Waste," EPA SW-846, 3rd Edition, EPA, Office of Solid Waste and Emergency Response, Washington, D.C., September 1986, and updated September 1994.

F1 "PCB's in Transformer Oil/Waste Oil," EPA 600/4-81-045, September 1982.

G "National Institute for Occupational Safety and Health Manual of Analytical Methods," U.S. Department of Health and Human Services, Cincinnati, Ohio, 3rd Edition, February 1984, updated May 1989.

H "Interim Method for Determination of Asbestos in Bulk Insulation Samples," EPA 600/4-82-020, EPA, Environmental Monitoring Systems Laboratory, Research Triangle Park, North Carolina, March 1982.

H1 "Analytical Method for Determination of Asbestos Fibers in Water," EPA/600/4-83-043, EPA, Environmental Research Laboratory, Athens, GA, September 1983.

I "Annual Book of ASTM Standards," Volume 11.01 and 11.02, Water and Environmental Technology, American Society for Testing and Materials, Philadelphia, Pennsylvania 1995.

J "Methods for Determination of Inorganic Substances in Water and Fluvial Sediments", U.S. Department of Interior, U.S. Geological Survey, Washington, D.C., 3rd Edition 1989.

K Test Methods for the Determination of: "Ethylene Dibromide and Dibromochloropropane in Water," BLS-127, revised June 1990; "TPH in Soil," 418.1AZ, revised September 7, 1994; "Ethylene Glycol in "Wastewater," BLS-188, revised April 1990; and "Quantitation of Fuel Class Hydrocarbons by GC," BLS-191, issued September 1991, Department of Health Services, Division of State Laboratory Services, Phoenix, Arizona.

L "Prescribed Procedures for Measurement of Radioactivity in Drinking Water," EPA 600/4-80-032, EPA, Environmental Monitoring and Support Laboratory, Cincinnati, Ohio, August 1980.

O "National Primary and Secondary Ambient Air Quality Standards," 40 CFR Part 50, Subchapter C, 1995.

P "USEPA Manual of Methods for Virology," EPA 600/4-84/013, EPA, Environmental Monitoring and Support Laboratory, Cincinnati, Ohio, February 1984.

Q "Standards of Performance For New Stationary Sources, Appendix A -Test Methods," 40 CFR Part 60, Appendix A, 1995.

R "Arizona Testing Manual For Air Pollutant Emissions," Arizona Office of Air Quality, Phoenix, Arizona, March 1992, Revision F.

S "National Emission Standards for Hazardous Air Pollutants, Appendix B Test Methods and Appendix C - Quality Assurance Procedures," 40 CFR Part 61, Appendix B and C, 1995.

T Broadway, et al., "Final Report of Equivalency Testing for Colisure," Montana State University, Bozeman, MT, September 29, 1992.

U "National Primary Drinking Water Regulations," 40 CFR Part 141, Subpart C, Appendix C, 1994.

V "The Determination of Inorganic Anions in Water by Ion Chromatography," EPA 600/4-84-017, EPA, Environmental Monitoring and Support Laboratory, Cincinnati, Ohio, August 1991.

W Environmental Measurements Laboratory (EML) Procedures Manual, HASL-300, Vol. 1, U.S. Department of Energy, 27th Edition, 1990, New York, N.Y.

X Radiochemistry Procedures Manual, Eastern Environmental Radiation Facility (EERF) EPA-Montgomery, EPA 520/5-84/006, Montgomery, AL, August 1984.

Y Radiochemical Analytical Procedures for Analysis of Environmental Samples, EPA, Environmental Monitoring and Support Laboratory (EMSL). EMSL-LV0539-17, Las Vegas, NV, March 1979.

Z "Test Methods for Escherichia coli in Drinking Water, EC Medium with Mug Tube Procedure, Nutrient Agar with Mug Membrane Filter Procedure, "EPA 600/4-91/016, EPA, Environmental Monitoring Systems Laboratory, Cincinnati, Ohio, July 1991.

Historical Note

Adopted effective August 16, 1985 (Supp. 85-4). Former Section R9-14-608 repealed, new Section R9-14-608 adopted effective December 20, 1991 (Supp. 91-4). Section citation corrected in preceding historical note; Section R9-14-608 renumbered to R9-14-609; new Section R9-14-608 renumbered from R9-14-607 and amended effective June 20, 1997 (Supp. 97-2).

R9-14-609. Drinking Water Sample Matrix

Every laboratory which conducts compliance testing under this rule shall follow the guidelines in Key Reference D3, excluding laboratory personnel educational and experience requirements, and use the following approved methods, unless a method falls under the alternate specifications pursuant to R9-14-608(A) or (B). To locate the source of the approved method, cross reference the capital letter listed under "Key" to the reference designation listed in R9-14-608. When the identification and measurement of radio nuclides other than those listed in subsections (E)(1) through (11) of this Section are required, Key reference "X" or "Y" is to be used, except in cases where alternative methods have been requested or approved in accordance with R9-14-608(A) through (C).

		Key	Approved Method
A.	Microbiology:	Key	Approved Method
	1. Total Coliforms:		
	Multiple Tube	C	9221
	Membrane Filter	C	9222B
	Coliert (OMPG-MUG)	C	9223B
	Colisure	T	Broadway et. al.
	Presence - Absence	C	9221E
	2. Heterotrophic Plate Count	C	9215B
	3. Escherichia coli	Z	Tube Procedure
			Membrane Filter Procedure
	4. Fecal coliform	C	9221E, 9222D
B.	Sample preparation for metals:	Key	Approved Method
	1. Preliminary Filtration	C	3030B
	2. Acid Extractable Metals	C	3030C
	3. Acid Digestion:		
	Nitric Acid	C	3030E
	Nitric Acid/Hydrochloric Acid	C	3030F
	Nitric Acid/Sulfuric Acid	C	3030G
	Nitric Acid/Perchloric Acid	C	3030H
	Nitric Acid/Perchloric Acid/Hydrofluoric Acid	C	3030I
	4. Dry Ashing	C	3030J
	5. Microwave Assisted Digestion	C	3030K
C.	Inorganic chemical and physical characteristics:	Key	Approved Method
	1. Alkalinity	C	2320
		I	D1067-92B
	2. Aluminum	A1	200.7, 200.8, 200.9

		C	3120B, 3113B, 3111D
		J	I-3051-85
3.	Antimony	A1	200.8, 200.9
		C	3113B
		I	D3697-92
4.	Arsenic	A1	200.7, 200.8, 200.9
		C	3113B, 3114B, 3120B
		I	
		J	I-1062-85
5.	Barium	A1	200.7, 200.8
		C	3111D, 3113B, 3120B
6.	Beryllium	A1	200.7, 200.8, 200.9
		C	3113B, 3120B
		I	D3645-93B
7.	Cadmium	A1	200.7, 200.8, 200.9
		C	3113B
8.	Calcium	A1	200.7
		C	3111B, 3120B, 3500-Ca D
		I	D511-93 A,B
9.	Chloride	A2	300.0
		C	4500-Cl D
10.	Chlorine, Total Residual	A2	330.1, 330.2, 330.3, 330.4, 330.5
		C	4500-Cl D,E,F,G,H
11.	Chlorine Dioxide	C	4500-ClO2 C,D,E
12.	Chromium, Total	A1	200.7, 200.8, 200.9
		C	3113B, 3120
13.	Color	C	2120 B,C,D
		J	I-1250-84
14.	Copper	A1	200.7, 200.8, 200.9
		C	3113B, 3120
		I	D1688-90A, D1688-90C
15.	Corrosivity	C	2330B
16.	Cyanide	A2	335.4
		C	4500-CN C,E,F
		I	D2036-91A
		J	I-3300-85
17.	Cyanide, Amenable	C	4500-CN G
		I	D2036-91B
18.	Fluoride	A2	300.0
		C	4500-F B,C,D,E, 4110B
		I	D1179-93B
19.	Hardneess	A1	Sum of Ca and Mg by 200.7 as their carbonates.
		C	2340B, Sum of Ca & Mg by ICP as their carbonates.
20.	Iron	A1	200.7, 200.9
		C	3111B, 3113B, 3120B
21.	Lead	A1	200.8, 200.9
		C	3113B
		I	D3559-90D
22.	Magnesium	A1	200.7
		C	3111B, 3120
23.	Manganese	A1	200.7, 200.8, 200.9
		C	3111B, 3113B, 3120B
		I	D858-90A, D858-90C
24.	Methylene Blue Active Substances	C	5540C
25.	Mercury	A	245.2
		A1	245.1, 200.8
		C	3112B
		I	D3223-91
26.	Nickel	A1	200.7, 200.8, 200.9
		C	3111B, 3113B, 3120B
27.	Nitrate	A2	353.2, 300.0
		C	4500-NO_3,D,E,F, 4110B
		I	D3867-90A, D3867-90B
28.	Nitrite	A2	353.2, 300.0

	C	4500-NO2 B,E,F, 4110B
	I	D3867-90A, D3867-90B
29. Ortho-Phosphate	A2	365.1, 300.0
	I	D-515-88A
	C	4500-P-E,F, 4110
	J	I-2601-85, I-2598-85
30. Ozone	C	4500-O3 B
31. pH (Hydrogen Ion)	A	150.1, 150.2
	C	4500-H B
	I	D1293-84
32. Residue, Filterable (TDS)	C	2540C
	J	I-1750-84
33. Temperature, Degrees Celsius	C	2550B
34. Turbidity, NTU: Nephelometric	A	180.1
	C	2130
35. Selenium	A1	200.8, 200.9
	C	3113B, 3114B
	I	D3859-93A, D3859-93B
	J	I-3667-85
36. Silica	A1	200.7
	C	4500-Si D,E,F, 3120B
	I	D859-88
	J	I-1700-85
37. Silver	A1	200.7, 200.8, 200.9
	C	3111B, 3113B, 3120B
	J	I-3720-85
38. Sodium	A1	200.7
	C	3111B, 3120B, D1428-82A
39. Specific Conductance	C	2510B
	I	D1125-91A
40. Strontium	A1	200.7
	C	3500-Sr B,C,D
41. Sulfate	A	375.2
	A2	300.0
	C	4110, 4500-SO4 C, D, F
	I	D4327-91
42. Thallium	A1	200.8, 200.9
43. Zinc	A1	200.7, 200.8
	C	3111B, 3120B
D. Organic chemicals:	Key	Approved Method
1. Total Trihalomethanes	D	502.2
	D1	551
	D2	524.2
2. Halogenated Volatiles	D	502.2
	D2	524.2
3. Aromatic Volatiles	D	502.2
	D2	524.2
4. Chlorinated Pesticides	D	505, 508, 508.1, 525.2
5. Polychlorinated Biphenyls (PCBs)	D	505, 508, 508A
6. Chlorophenoxy Herbicides	C	6640B
	D	515.1
	D2	515.2, 555
	I	D3478-85
7. 1,2-Dibromoethane (EDB)	D	504.1
	D1	551
	K	BLS-127
8. 1,2-Dibromo-3-Chloropropane (DBCP)	D	504.1
	D1	551
	K	BLS-127
9. Nitrogen and Phosphorus Pesticides	D	507, 525.2
10. Base/Neutrals and Acids	D	525.2
11. Carbamates	D	531.1
12. Dioxins and Furans	D5	1613
13. Glyphosate	D1	547
14. Endothall	D2	548.1
15. Diquat and Paraquat	D2	549.1

16. Polycyclic Aromatic Hydrocarbons	D	525.2
	D1	550, 550.1
17. DBPs and Chlorinated Solvents	D1	551
18. Haloacetic Acids	D1	552
	D2	552.1
19. Phthalate Esters and Adipates	D	525.2
	D1	506
20. Benzidines and Nitrogen Pesticides	D2	553
21. Carbonyl Compounds	D2	554
22. Chlorinated Acids	D2	555
E. Radiochemical:	Key	Approved Method
1. Gross Alpha	B	Gross Alpha
	C	7110B
	L	900
2. Gross Beta	B	Gross Beta
	C	7110B
	L	900
3. Total Radium	B	Total Radium
	C	7500-Ra B
	L	903
4. Radium-226	B	Radium-226
	C	7500-Ra B
	L	903.1
5. Radium-228	L	904
6. Cesium-134	B	Cesium-134
	C	7500-Cs B
	L	901
7. Iodine-131	B	Iodine-131
	C	7500-I B, C
	L	902
8. Radon-222	L	Lucas Cell
9. Strontium	B	Strontium
	C	7500-Sr B
	L	905
10. Tritium	B	Tritium
	C	7500-H B
	L	906
11. Uranium	B	Uranium
	C	7500-U B, C
	L	908, 908.1
	I	D2907-83
12. Gamma Emitting Isotopes	L	901.1

Historical Note

Adopted effective December 20, 1991 (Supp. 91-4). Former Section R9-14-609 renumbered to R9-14-610; new Section R9-14-609 renumbered from R9-14-608 and amended effective June 20, 1997 (Supp. 97-2).

R9-14-610. Wastewater Sample Matrix

Every laboratory which conducts compliance testing under this rule shall use the following approved methods, unless a method falls under an alternate method pursuant to R9-14-608(A) or (B). To locate the source of the approved method, cross reference the capital letter listed under "Key" to the reference designation listed in R9-14-608(C).

A. Microbiology:	Key	Approved Method
1. Fecal Coliforms:		
Multiple Tube Fermentation	C	9221E
Membrane Filter	C	9222D
	J	B-0050-85
2. Total Coliforms:		
Multiple Tube Fermentation	C	9221B
Membrane Filter	C	9222B
	J	B-0025-77
3. Fecal Streptococcus:		
Multiple-Tube	C	9230B
Membrane Filter	C	9230C
	J	B0055-85
4. Viruses	P	Methods for Virology
	C	9510

B. Inorganic chemicals, nutrients and demand:	Key	Approved Method
1. Acidity	A	305.1
	C	2310B
	I	D1067-92
2. Alkalinity, Total	A	310.1, 310.2
	C	2320B
	I	D1067-92
	J	I-1030-85, I-2030-85
3. Aluminum	A	202.1, 202.2
	A1	200.7, 200.8, 200.9
	C	3113B, 3111D, 3120B
	J	I-3051-85
4. Ammonia	A	350.1, 350.2, 350.3
	C	4500-NH3 B, C, E, F, G, H
	I	D1426-89A, D1426-89B
	J	I-3520-85, I-4523-85
5. Antimony	A	204.1, 204.2
	A1	200.7, 200.8, 200.9
	C	3113B, 3120B, 3111B
6. Arsenic	A	206.2, 206.3, 206.4, 206.5
	A1	200.7, 200.8, 200.9
	C	3113B, 3500-As B, C, 3120B
	I	D2972-88A, B, C
	J	I-3060-85, I-3062-85
7. Barium	A	208.1, 208.2
	A1	200.7, 200.8
	C	3111, 3113B, 3120B
	I	D4382-91
	J	I-3084-85
8. Beryllium	A	210.1, 210.2
	A1	200.7, 200.8, 200.9
	C	3111, 3111D, 3113B, 3120B, 3500-Be
	I	D3645-84A, D364588B, D419088
	J	I-3095-85
9. Biochemical Oxygen Demand	A	405.1
	C	5210B
	J	I-1578-78
10. Boron	A	212.3
	A1	200.7
	C	3120B, 4500-B B
	J	I-3112-85
11. Bromide	A	320.1
	A2	300.0
	I	D1246-88C
	J	I-1125-85
12. Cadmium	A	213.1, 213.2
	A1	200.7, 200.8, 200.9
	C	3111B, C, 3113B, 3120B, 3500-Cd D
	D	3557-90 A, B, C, D4190-82
	J	I-3135-85, I-3136-85
13. Calcium	A	215.1, 215.2
	A1	200.7
	C	3111, 3120B, 3500-Ca D
	I	D511-92A, D511-92B
	J	I-3152-85
14. Chemical Oxygen Demand	A	410.1, 410.2, 410.3, 410.4
	C	5220B, C, D
	C1	8000
	I	D-1252-88A, B
	J	I-3560-85, I-3561-85, I-3562-85
15. Chloride		A325.1, 325.2, 325.3
	A2	300.0
	C	4500-Cl B, C, E
	I	D512-89A, D512-89B
	J	I-1183-85, I-1187-85,

		I-2187-85, I-1184-85
16. Chlorine, Total Residual	A	330.1, 330.2, 330.3, 330.4, 330.5
	C	4500-Cl B, C, D, F, G
	I	D1253-86
17. Chromium, Hexavalent	A	218.4
	C	3500-Cr D, 3111C
	I	D1687-92A
	J	I-1230-85, I-1232-85
18. Chromium, Total	A	218.1, 218.2, 218.3
	A1	200.7, 200.8, 200.9
	C	3111B, C, 3113B, 3120B, 3500-Cr D
	I	D1687-92A, B, C, D4190-82
	J	I-3236-85
19. Cobalt	A	219.1, 219.2
	A1	200.7, 200.8, 200.9
	C	3111B, C, 3113B, 3120B
	I	D3550-90A, B, D4190-82
	J	I-3239-85
20. Color	A	110.1, 110.2, 110.3
	C	2120B, 2120C, 2120E
	J	I-1250-85
21. Copper	A	220.1, 220.2
	A1	200.7, 200.8, 200.9
	C	3111B, C, 3113B, 3120B, 3500-Cu D, E
	C1	8506
	I	D1688-90A, B, C, D4190-82
	J	I-3270-85, I-3271-85
22. Cyanide, Amenable to Chlorination	A	335.1
	C	4500-CN G
	I	D2036-91B
23. Cyanide, Total	A	335.2, 335.3
	C	4500-CN C, D, E
	I	D2036-91A
	J	I-3300-85
24. Fluoride	A	340.1, 340.2, 340.3
	A2	300.0
	C	4500-F B, C, D, E
	I	D1179-88A, D1179-88B
	J	I-4327-85
25. Gold	A	231.1, 231.2
	C	3111B
26. Hardness	A	130.1, 130.2, Sum of ICP Ca & Mg their carbonates
	A1	200.7
	C	2340B, 2340C
	I	D1126-86
	J	I-1338-85
27. Iridium	A	235.1, 235.2
	C	3111B
28. Iron	A	236.1, 236.2
	A1	200.7, 200.9
	C	3111B, C, 3113B, 3120 B, 3500-Fe D
	C2	8008
	I	D1068-90 A, B, C, D, 4190-82
	J	I-3381-85
29. Kjeldahl, Total Nitrogen	A	351.1, 351.2, 351.3, 351.4
	C	4500-NH3 B, C, E, F, G3
	I	D3590-89A, D3590-89B
	J	I-4551-78
30. Lead	A	239.1, 239.2
	A1	200.7, 200.8, 200.9
	C	3111B, C, 3113B, 3120B, 3500-Pb D
	I	D3559-85 A, B, C, D, D4190-82
	J	I-3399-85
31. Magnesium	A	242.1

	A1	200.7
	C	3111B, 3500-Mg D, 3120B
	I	D511-92B
	J	I-3447-85
32. Manganese	A	243.1, 243.2
	A1	200.7, 200.8, 200.9
	C	3111B, 3113B, 3120B, 3500-Mn, D
	C1	8034
	J	I-3454-85
33. Mercury	A	245.2
	A1	245.1
	C	3112B
	I	D3223-91
	J	1-3462-85
34. Molybdenum	A	246.1, 246.2
	A1	200.7, 200.8
	C	3111D, 3113B, 3120B
	J	I-3490-85
35. Nickel	A	249.1, 249.2
	A1	200.7, 200.8, 200.9
	C	3111B, C, 3113B, 3120B, 3500-Ni D
	I	D1886-90A, B, C, D4190-82
	J	I-3499-85
36. Nitrate	A	352.1, 353.1, 353.2, 353.3
	A2	300.0
	C	4500-NO3 E, F, H
	I	D3867-90A, D3867-90 B
	J	I-4545-85
37. Nitrite	A	354.1
	A2	300.0
	C	4500-NO_2
	C1	8607
	J	I-4540-85
38. Oil and Grease	A	413.1
	C	5520B
39. Organic Carbon, Total (TOC)	A	415.1
	C	5310B, C, D
	I	D2579-85A, D2579-85B
40. Orthophosophate	A	365.1, 365.2, 365.3
	A2	300.0
	C	4500-P, E, F
	I	D515-88A
	J	I-4601-85
41. Osmium	A	252.1, 252.2
	C	3111D
42. Oxygen, Dissolved	A	360.1, 360.2
	C	4500-O C, 4500-O G
	I	D888-92A, B
	J	I-1575-78, I-1576-78
43. Palladium	A	253.1, 253.2
	C	3111B
44. pH (Hydrogen Ion)	A	150.1
	C	4500-H B
	I	D1293-84A, D1293-84B
	J	I-1586-85
45. Phosphorus, Total	A	365.1, 365.2, 365.3, 365.4
	C	4500-P B, E, F
	I	D515-88A, D515-88B
	J	I-4600-85
46. Platinum	A	255.1, 255.2
	C	3111B
47. Potassium	A	258.1
	A1	200.7
	C	3111B, 3500-K D, 3120B
	J	I-3630-85
48. Residue, Total	A	160.3

	C	2540B
	J	I-3750-85
49. Residue, Filterable (TDS)	A	160.1
	C	2540C
	J	I-1750-85
50. Residue, Nonfilterable (TSS)	A	160.2
	C	2540D
	J	I-3765-85
51. Residue, Settleable Solids	A	160.5
	C	2540F
52. Residue, Volatile	A	160.4
	J	I-3753-85
53. Rhodium	A	265.1, 265.2
	C	3111B
54. Ruthenium	A	267.1, 267.2
	C	3111B
55. Selenium	A	270.2
	A1	200.7, 200.8, 200.9
	C	3113B, 3114B, 3120B
	I	D3859-88A
	J	I-3667-85
56. Silica, Dissolved	A	370.1
	A1	200.7
	C	4500-Si D, 3120B
	I	D859-88
	J	I-1700-85, I-2700-85
57. Silver	A	272.1, 272.2
	A1	200.7, 200.8, 200.9
	C	3111B, C, 3113B, 3120B
	J	I-3720-85
58. Sodium	A	273.1
	A1	200.7
	C	3111B, 3120B
	J	I-3735-85
59. Sodium Azide	C	4110C
60. Sodium/Potassium Perchlorate	V	300.0
61. Specific Conductance	A	120.1
	C	2510B
	I	D1125-91A
	J	I-1780-85
62. Strontium	A1	200.7
	C	3111, 3500-Sr B, C 3120B
63. Sulfate	A	375.1, 375.3, 375.4
	A2	300.0
	C	4500-SO_4 C, D
	I	D516-90
64. Sulfide	A	376.1, 376.2
	C	4500-S D, 4500-S E
	J	I-3840-85
65. Sulfite	A	377.1
	C	4500-SO3 B
66. Surfactants (MBAS)	A	425.1
	C	5540C
	I	D2330-88
67. Temperature Degrees Celsius	A	170.1
	C	2550B
67. Thallium	A	279.1, 279.2
	A1	200.7, 200.8, 200.9
	C	3111B, 3120B
69. Tin	A	282.1, 282.2
	A1	200.7, 200.9
	C	3111B, 3113B
	J	I-3850-78
70. Titanium	A	283.1, 283.2
	C	3111D
71. Turbidity, NTU	A	180.1

		C	2130B
		I	D1889-88A
		J	I-3860-85
72.	Vanadium	A	286.1, 286.2
		A1	200.7, 200.8
		C	3111D, 3500-V, D, 3120B
		I	D4190-82
73.	Zinc	A	289.1, 289.2
		A1	200.7, 200.8, 200.9
		C	3111B, C, 3120B, 3500-Zn E, F
		C1	8009
		I	D1691-90A, B, D4190-82
		J	I-3900-85
C.	Aquatic toxicity and bioassay:	Key	Approved Method
	Static, Static/Renewal and Flow-Through	C	8711, 8910
D.	Organic chemical:	Key	Approved Method
1.	Halogenated Volatiles	E	601
2.	Aromatic Volatiles	E	602
3.	Acrolein and Acrylonitrile	E	603
4.	Phenols	E	604
5.	Benzidines	E	605
6.	Phthalate Esters	E	606
7.	Nitrosamines	E	607
8.	Organochlorine Pesticides and PCBs	E	608
9.	Nitroaromatics and Isophorone	E	609
10.	Polynuclear Aromatic Hydrocarbons	E	610
11.	Haloethers	E	611
12.	Chlorinated Hydrocarbons	E	612
13.	2, 3, 7, 8-Tetrachlorodibenzo-p-Dioxin	E	613
14.	Triazine Pesticides	E	619
15.	Purgeables	E	624, 1624
16.	Base/Neutrals and Acids	E	625, 1625
17.	Carbamates and Urea Pesticides	E	632
18.	Total Petroleum Hydrocarbons	A	418.1
19.	Ethylene Glycol in Wastewater	K	BLS-188
E.	Radiochemical:	Key	Approved Method
1.	Gross Alpha	C	7110B
		I	D1943-90
		L	900
2.	Gross Beta	C	7110B
		I	D1890-90
		L	900.0
3.	Total Radium	C	7500-Ra B
		I	D2460-90
		L	903.0
4.	Radium-226	C	7500-Ra C
		I	D3454-91
		L	903.1

Historical Note

Adopted effective December 20, 1991 (Supp. 91-4). Former Section R9-14-610 renumbered to R9-14-611; new Section R9-14-610 renumbered from R9-14-609 and amended effective June 20, 1997 (Supp. 97-2).

R9-14-611. Solid, Liquid, and Hazardous Waste Sample Matrix

Every laboratory which conducts compliance testing under this rule shall use the following approved methods, unless required by ADEQ or EPA, or unless a method falls under an alternate method pursuant to R9-14-608(A) or (B). To locate the source of the approved method, cross reference the capital letter listed under "Key" to the reference designation listed in R9-14-608(C).

A.	Microbiology:	Key	Approved Method
1.	Total Coliforms:		
	Multiple Tube Fermentation	F	9131
	Membrane Filter	F	9132
B.	Hazardous waste characteristics:	Key	Approved Method
1.	Corrosivity:		
	pH determination	F	9040A, 9041A
	corrosive to steel	F	1110
	Dermal	F	1120
2.	Ignitability	F	1010, 1020A, 1030

	3. Reactivity	F	Reactivity
C.	Sample extraction procedures:	Key	Approved Method
	1. Extraction Procedure Toxicity (EP TOX)	F	1310A
	2. Toxicity Characteristic Leaching Procedure (TCLP)	F	1311
	3. Multiple Extraction Procedure	F	1320
	4. Extraction Procedure For Oily Waste	F	1330A
	5. Synthetic Precipitation Leaching Procedure (SPLP)	F	1312
D.	Metals sample preparation:	Key	Approved Method
	1. Dissolved in Water	F	3005A
	2. Total Recoverable in Water	F	3005A
	3. Total Metals	F	3010A, 3120A
	4. Oils, Greases, and Waxes	F	3040, 3031
	5. Sediments, Sludges, and Soils	F	3050A
	6. Microwave Assisted Digestions	F	3015, 3051
E.	Inorganic chemical:	Key	Approved Method
	1. Aluminum	F	6010A, 6020, 7020
	2. Antimony	F	6010A, 6020,7040, 7041, 7062
	3. Arsenic	F	6010A, 7060A 7061A, 7062, 7063, 6020
	4. Barium	F	6010A, 6020,7080A, 7081
	5. Beryllium	F	6010A, 6020, 7090, 7091
	6. Cadmium	F	6010A, 6020, 7130, 7131A
	7. Calcium	F	6010A, 7140
	8. Chromium, Total	F	6010A, 6020, 7190, 7191
	9. Chromium, Hexavalent	F	7195, 7196A, 7197, 7198, 7199
	10. Cobalt	F	6010A, 6020, 7200, 7201
	11. Copper	F	6010A, 6020, 7210, 7211
	12. Iron	F	6010A, 7380, 7381
	13. Lead	F	6010A, 6020, 7420, 7421
	14. Lithium	F	6010A, 7430
	15. Magnesium	F	6010A, 7450
	16. Manganese	F	6010A, 6020, 7460, 7461
	17. Mercury	F	7470A, 7471A, 7472
	18. Molybdenum	F	6010A, 7480, 7481
	19. Nickel	F	6010A, 6020, 7520, 7521
	20. Osmium	F	6010A, 7550
	21. Potassium	F	6010A, 7610
	22. Selenium	F	6010A, 7740, 7741A, 7742
	23. Silver	F	6010A, 6020, 7760A, 7761
	24. Sodium	F	6010A, 7770
	25. Strontium	F	6010A, 7780
	26. Thallium	F	6010A, 6020, 7840, 7841
	27. Tin	F	6010A, 7870
	28. Vanadium	F	6010A, 7910, 7911
	29. Zinc	F	6010A, 6020, 7950, 7951
	30. White Phosphorus by GC	F	7580
F.	Sample preparation and extraction:	Key	Approved Method
	1. Preparation and Extraction	F	3500A
	2. Funnel Liquid-Liquid Extraction	F	3510B
	3. Continuous Liquid-Liquid Extraction	F	3520B
	4. Solid Phase Extraction	F	3535
	5. Soxhlet Extraction	F	3540B, 3541
	6. Accerated Solvent Extraction	F	3545
	7. Sonication Extraction	F	3550A
	8. Supercritical Fluid Extraction	F	3560, 3561
	9. Waste Dilution	F	3580A, 3585
	10. Purge and Trap	F	5030A
	11. Sorbent Cartridges from Organic Sampling Train	F	5041
	12. Cyanide Extraction for Solids and Oils	F	9013
	13. Bomb Preparation Method for Solid Waste	F	5050
G.	Sample cleanup:	Key	Approved Method
	1. Cleanup	F	3600B
	2. Alumina Column	F	3610A
	3. Alumina Column - petroleum wastes	F	3611A
	4. Florisil Column	F	3620A
	5. Silica Gel Cleanup	F	3630B

6.	Gel-Permeation Cleanup	F	3640A
7.	Acid-Base Partition	F	3650A
8.	Sulfur Cleanup	F	3660A
9.	Sulfuric Acid/Permanganate Cleanup	F	3665
H.	Organic chemical:	Key	Approved Method
1.	EDB and DBCP	F	8011
2.	Nonhalogenated Volatile Organics	F	8015A, 8015M
3.	Volatile Organics	F	8021A, 8260A
4.	Acrolein/Acrylonitrile/Acetonitrile	F	8316
5.	Acrylonitrile	F	8031
6.	Acrylamide	F	8032
7.	Acetonitrile	F	8033
8.	Phenols	F	8041
9.	Phthalate Esters	F	8061
10.	Nitrosamines	F	8070, 8330
11.	Organochlorine Pesticides and PCBs	F	8081, 8082
12.	PCBS in Waste Oil	F1	EPA-600/4-81-045
13.	Nitroaromatics and Cyclic Ketones	F	8330, 8091
14.	Polynuclear Aromatic Hydrocarbons	F	8100, 8310
15.	Haloethers	F	8111
16.	Chlorinated Hydrocarbons	F	8121
17.	Organophosphorus Pesticides	F	8141A
18.	Chlorinated Herbicides	F	8151
19.	Semivolatile Organics GC/MS	F	8270B, 8275A
20.	Semi-Volatiles by GC/FT-IR	F	8410
21.	Polychlorinated Dibenzo-p-Dioxins and Polychlorinated Dibenzofurans	F	8280, 8290
22.	Carbonyl Compounds	F	8315
23.	N-Methylcarbamates	F	8318
24.	Non-Volatile Organics (HPLC/TSP/MS)(HPLC/PB/MS)	F	8321, 8325
25.	Tetrazine	F	8331
26.	Total Petroleum Hydrocarbons in Soil	K	418.1AZ, 8440
27.	Fuel Class Hydrocarbons	K	BLS-191
28.	Trinitrotoluene	F	4050
29.	RDX by Immunoassay	F	4051
30.	Aniline and Derivatives	F	8131
31.	Nitroglycerine	F	8332
32.	Bis(2-chloroethyl)Ether Hydrolysis Products	F	8430
I.	Organic chemical screening:	Key	Approved Method
1.	Headspace	F	3810, 5021
2.	Purgeables after Hexadecane Extraction	F	3820
3.	Semivolatile Organics TC/MS	F	8275
4.	Immunoassay	F	4010, 4015, 4020, 4030 4035, 4040, 4041, 4042
5.	Polychlorinated Biphenyls	F	9078, 9079
6.	Trinitrotoluene	F	8515
J.	Miscellaneous:	Key	Approved Method
1.	Cyanide	F	9010A, 9012, 9213
2.	Total Organic Halides (TOX)	F	9020B, 9022
3.	Purgeable Organic Halides (POX)	F	9021
4.	Extractable Organic Halides (EOX)	F	9023
5.	Sulfides	F	9030A, 9031, 9215
6.	Sulfate	F	9035, 9036, 9038, 9056
7.	pH (Hydrogen ion)	F	9040A, 9041A, 9045B
8.	Specific Conductance	F	9050
9.	Total Organic Carbon (TOC)	F	9060
10.	Phenolics	F	9065, 9066, 9067
11.	Total Recoverable Oil an Grease	F	9070, 9071A
12.	Nitrate	F	9210, 9056
13.	Nitrite	F	9056
14.	Chloride	F	9250, 9251, 9252A, 9057, 9212
15.	Bromide	F	9056, 9211
16.	Fluoride	F	9056, 9214
17.	Total Chlorine in New and Used Petroleum Products	F	9075, 9076, 9077
18.	Cation-Exchange Capacity of Soils	F	9080, 9081
19.	Compatibility Test For Wastes and Membrane Liners	F	9090A
20.	Paint Filter Liquids Test	F	9095

21.	Liquid Release Test Procedure	F	9096
22.	Saturates Hydraulic and Leachate Conductivity, and Intrinsic Permeability	F	9100
23.	Chloride	F	9056
24.	O-Phosphate-P	F	9056
K.	Asbestos:	Key	Approved Method
1.	Fiber Counting	G	7400, 7402
2.	Bulk Asbestos	G	9002
		H	Bulk Asbestos
L.	Radiochemical:	Key	Approved Method
1.	Gross Alpha and Beta	F	9310
2.	Alpha-Emitting Radium Isotopes	F	9315
3.	Radium-228	F	9320

Historical Note

Adopted effective December 20, 1991 (Supp. 91-4). Former Section R9-14-611 renumbered to R9-14-612; new Section R9-14-611 renumbered from R9-14-610 and amended effective June 20, 1997 (Supp. 97-2).

R9-14-612. Air Sample Matrix

Every laboratory which conducts compliance testing under this rule shall use the following approved methods, unless a method falls under an alternate method pursuant to R9-14-608(A) or (B). To locate the source of the approved method, cross reference the capital letter listed under "Key" to the reference designation listed in R9-14-608(C).

A.	Ambient air:	Key	Approved Method
1.	Carbon Monoxide	O	Appendix C
2.	Hydrocarbons	O	Appendix E
3.	Lead	O	Appendix G
4.	Nitrogen Dioxide	O	Appendix F
5.	Ozone	O	Appendix D, H
6.	Particulate Matter	O	Appendix B, J, K
7.	Sulfur Oxides	O	Appendix A
8.	Formaldehyde	F	8520
B.	Stationary and stack sources:	Key	Approved Method
1.	Carbon Dioxide, Oxygen, and Excess Air	Q	Method 3
2.	Carbon Monoxide	Q	Method 10, 10A, 10B
3.	Carbonyl Sulfide, Hydrogen Sulfide, and Carbon Disulfide	Q	Method 15
4.	Fluoride	Q	Method 13A, 13B, 14
5.	Fugitive Emissions	Q	Method 22
6.	Gaseous Organic Compounds	Q	Method 18, 25, 25A, 25B
7.	Hydrogen Sulfide	Q	Method 11
8.	Inorganic Lead	Q	Method 12
9.	Moisture Content	Q	Method 4
10.	Nitrogen Oxide	Q	Method 7, 7A, 7B, 7C, 7D, 7E, 19, 20
11.	Particulate Emissions:		
	Asphalt Processing	Q	Method 5A
	Fiberglass Insulation	Q	Method 5E
	Nonsulfate	Q	Method 5F
	Nonsulfuric Acid	Q	Method 5B
	Pressure Filters	Q	Method 5D
	Stationary Sources	Q	Method 5, 17
	Sulfur Dioxide	Q	Method 19
	Wood Heaters	Q	Method 5G, 5H
12.	Sulfur and Total Reduced Sulfur	Q	Method 15A, 16, 16A, 16B
13.	Sulfur Dioxide	Q	Method 6, 6A, 6B, 6C, 8, 19, 20
14.	Sulfuric Acid Mist	Q	Method 8
15.	Vapor Tightness Gasoline Delivery Tank	Q	Method 27
16.	Volatile Matter, Density Solids and water	Q	Method 24, 24A
17.	Volatile Organic Compounds	Q	Method 21
18.	Wood Heaters Certification and Burn Rates	Q	Method 28, 28A
C.	ADEQ emission tests:	Key	Approved Method
1.	Particulate Emissions:		
	Sulfuric Acid Mist/Sulfur Oxides	R	Method A1
	Dry Matter	R	Method A2

		Key	Approved Method
D.	National emission standards for hazardous air pollutants:		
1.	Arsenic	S	Method 108, 108A, 108B, 108C
2.	Beryllium	S	Method 103, 104
3.	Mercury	S	Method 101, 101A, 102, 105
4.	Polonium-210	S	Method 111
5.	Vinyl Chloride	S	Method 106, 107, 107A

Historical Note

Adopted effective December 20, 1991 (Supp. 91-4). Former Section R9-14-612 renumbered to R9-14-613; new Section R9-14-612 renumbered from R9-14-611 and amended effective June 20, 1997 (Supp. 97-2).

R9-14-613. Quality Assurance

A. The laboratory shall have a written quality assurance plan that describes actions to be taken by the lab to ensure that routinely generated analytical data are scientifically valid and defensible and are of known and acceptable precision and accuracy. The written plan shall contain:
1. A title page identifying the laboratory, date of review, and the laboratory director's signature of approval;
2. A table of contents;
3. A detailed statement of the laboratory organization, line of authority, and identification of principal quality assurance personnel;
4. A statement of quality assurance objectives, including data quality objectives with precision and accuracy goals, and criteria for the laboratory to judge the acceptability of each testing;
5. Specifications for:
   a. The use of proper sample containers;
   b. The proper preparation of sample containers;
   c. The proper preservation of samples; and
   d. Compliance sample maximum allowable holding times;
6. A procedure for documenting laboratory receipt of samples and tracking of samples throughout laboratory testing;
7. A procedure for analytical instrument calibration and frequency;
8. A copy of the laboratory's current license and list of licensed parameters;
9. A listing of the procedures for compliance testing data reduction, validation, and reporting. These procedures shall include the identification and treatment of data outliers, the determination of the completeness and accuracy of data transcription and all calculations;
10. A statement of the frequency of use and acceptance tolerance of all compliance testing quality control checks;
11. Preventive maintenance procedures and schedules;
12. Assessment procedures for data acceptability;
13. Corrective action procedures taken when results from analytical quality control checks are unacceptable. These procedures shall include the steps taken to demonstrate the presence of any interference if the precision, accuracy, or the practical quantitation limit of the reported compliance testing result is affected by the interference; and
14. Procedures for chain-of-custody documentation, including procedures for the documentation and reporting of any deviation from the sample handling or preservation requirements listed in this Section.

B. The laboratory shall:
1. Have available on the premises all methods, equipment, reagents, and glassware necessary for the compliance testing for which the laboratory is licensed or is requesting licensure. If the laboratory documents its ability to perform the approved method and ensures that the analytical data generated are scientifically valid and defensible and are of known and acceptable precision and accuracy it may petition for an exemption only from this subsection;
2. Use only reagents of a grade equal to or greater than that called for by the approved methods referenced in R9-14-609 through R9-14-612;
3. Maintain complete and current Standard Operating Procedures (SOPs) for all licensed methods;
4. Calibrate equipment according to the manufacturer's specifications and as required by the approved method;
5. Maintain calibration logs available for on-site review. Calibration and documentation thereof by a laboratory instrument service organization is acceptable;
6. Develop, document, and maintain current method detection limits and practical quantitation limits for each compliance parameter, approved method and sample matrix for each instrument of use;
7. Maintain all compliance testing equipment in good working order;
8. Maintain quality control charts which demonstrate the accuracy and precision of its compliance testing;
9. If a laboratory tests for a parameter for which quality control acceptance criteria is not specified, the laboratory must statistically develop limits from historical data. The mean and standard deviation for a minimum of 20 data points, excluding statistical outliers, must be determined. The limits shall be no more than 3 standard deviations from the mean and shall be in the detectable range; and
10. Discard or segregate all expired standards or reagents from all compliance testing.

Historical Note

Adopted effective December 20, 1991 (Supp. 91-4). Former Section R9-14-613 renumbered to R9-14-614; new Section R9-14-613 renumbered from R9-14-612 and amended effective June 20, 1997 (Supp. 97-2).

R9-14-614. Operation

A. All samples accepted by a laboratory for compliance testing shall be analyzed by that laboratory, except that samples, other than those submitted for performance evaluation audit purposes, may be forwarded to another laboratory licensed under this Article or certified by EPA for examination.

B. If the laboratory performing an examination is not the laboratory which accepted the sample, all reports shall include the name and address of the laboratory accepting the sample and the name and address of the laboratory actually examining the sample.

C. The laboratory shall:
1. Maintain the facility and utilities required for proper equipment operation and use of compliance testing approved methods;
2. Provide environmental controls such that laboratory conditions do not affect analytical results beyond established quality control limits established for the approved methods listed in R9-14-609 through R9-14-612;

3. Provide for storage, handling, and disposal of hazardous materials in accordance with all state and federal regulations; and
4. Maintain documentation on all analytical personnel involved in compliance testing. The documentation shall provide that all these personnel have been trained in the test procedures prior to their performance of unmonitored testing and the documentation shall include:
   a) Summary of analyst's education and professional experience.
   b) Verification of the analyst's review of the laboratory Quality Assurance Plan, and the approved methods and laboratory Standard Operating Procedures used by the analyst for compliance testing.
   c) Verification of the analyst's completion of monitored training which includes the actual use of the equipment and the use of proper laboratory technique. Verification shall include the name of the instructor, the duration of the training, and the date of completion of the training.
   d) Verification of the analyst's completion of training classes, continuing education courses, seminars, and/or conferences, which relate to the testing procedures used by the analyst for compliance testing.
   e) Verification of the analyst's successful completion of Initial Demonstration of Capability as required by the approved methods.
   f) Records of analysis of proficiency evaluation testing.

Historical Note

Adopted effective December 20, 1991 (Supp. 91-4). Former Section R9-14-614 renumbered to R9-14-615; new Section R9-14-614 renumbered from R9-14-613 and amended effective June 20, 1997 (Supp. 97-2).

R9-14-615. Laboratory Records and Reports

A. Records and reports required to be maintained by this Article shall be available for inspection and copying during normal business hours by representatives of the Department. Copied records can be removed from the laboratory by the Department.

B. Records and reports of compliance testing shall be kept by the laboratory for at least 5 years. Records and reports for the most current 2 years shall be kept on-site and the remaining records and reports may be stored in a secure and easily accessible storage facility.

C. If Arizona compliance data is not available for inspection and copying, the laboratory shall make available for inspection and copying any current non-Arizona compliance data requested by Department representatives to evaluate methods and procedures applied for by the laboratory.

D. Compliance testing records shall contain:
1. Sample information including a unique sample identification assigned by the laboratory, location or location code of sample collection, sample collection date and time, type of testing to be performed and the name of person who collected the sample;
2. The name and address of the facility or person submitting the sample to the laboratory;
3. The date, time and name of the person who receives the sample into the laboratory;
4. The date and time of testing;
5. The actual results of compliance testing, including all raw data, work sheets, and calculations performed;
6. The actual results of quality control data validating the test results including calibration and calculations performed;
7. The name of the person or persons performing the test; and
8. A copy of the final report.

E. Complete laboratory personnel records shall be maintained as to:
1. Academic training;
2. Experience;
3. Qualifications; and
4. Applicable certifications and/or specialized training.

F. Analytical instrumentation performance records shall be maintained to demonstrate consistent standardization performance with standardized reference materials.

G. Reports of compliance testing shall contain:
1. Laboratory name, address, and telephone number;
2. Laboratory license number issued by the Department;
3. Result of compliance testing in appropriate units of measure:
   a) Actual scientifically valid and defensible results of compliance testing in appropriate units of measure, obtained in accordance with the approved method and the laboratory Quality Assurance Plan, as described in R9-14-613, by use of proper laboratory technique.
   b) Any result not obtained in accordance with the approved method and the laboratory Quality Assurance Plan by use of proper laboratory technique, shall be documented as such on the report.
4. A listing of each approved method used associated with the reported result;
5. Sample information including the unique sample identification assigned by the laboratory, location or location code of sample collection, sample collection date and time, the name of the person who collected the sample, and the facility or person who submitted the sample to the laboratory;
6. The date of the final report; and
7. Laboratory director's or designee signature.

Historical Note

Adopted effective December 20, 1991 (Supp. 91-4). Former Section R9-14-615 renumbered to R9-14-616; new Section R9-14-615 renumbered from R9-14-614 and amended effective June 20, 1997 (Supp. 97-2).

R9-14-616. Laboratory Safety

Licensed environmental laboratories shall comply with all applicable federal, state, and local regulations regarding occupational safety and health.

Historical Note

Adopted effective December 20, 1991 (Supp. 91-4). Former Section R9-14-616 renumbered to R9-14-617; new Section R9-14-616 renumbered from R9-14-615 effective June 20, 1997 (Supp. 97-2).

R9-14-617. Mobile Laboratories

A. A laboratory license is required for each mobile laboratory, unless the laboratory owner chooses the single licensure option described in R9-14-606(B). All requirements of this Article shall be met by the mobile laboratory.

B. Upon request, the owner of the mobile laboratory shall provide information of its location and scope of its compliance testing to the Department.

Historical Note

Adopted effective December 20, 1991 (Supp. 91-4).
Former Section R9-14-617 renumbered to R9-14-618;
new Section R9-14-617 renumbered from R9-14-616 and
amended effective June 20, 1997 (Supp. 97-2).

R9-14-618. Out-of-State Environmental Laboratory Licensure

A. Out-of-state laboratories applying for an initial license or a renewal license shall comply with the requirements of A.R.S. §§ 36-495 through 36-495.15 and this Article.

B. In addition to licensure fees, an out-of-state laboratory shall pay all actual expenses incurred by the Department as a result of its location in another state.

C. An out-of-state laboratory shall pay an amount sufficient to cover:

1. The estimated cost of all routine inspections during the licensure period of that laboratory,
2. The amount the actual costs of routine lab inspections exceed the estimated costs, and
3. Additional expenses incurred by the Department for each on-site investigation.

Historical Note

R9-14-618 renumbered from R9-14-617 and amended
effective June 20, 1997 (Supp. 97-2).

ARTICLE 7. HEALTH SCREENING SERVICES

R9-14-701. Definitions

In this Article, unless the context otherwise requires:

1. "Health care provider" means an attending physician or individual licensed and recognized as primarily responsible for diagnosis and treatment or initiating diagnosis, testing, or therapy of a patient pursuant to A.R.S. Title 32, Chapters 7, 8, 13, 14, 17, 25, or 29; or any person licensed or certified as a nurse practitioner pursuant to A.R.S. Title 32, Chapter 15 and A.A.C. R4-19-503.
2. "Image receptor" means any device, including fluorescent screen or radiographic film, which transforms incident ionizing radiation either into a visible image or into another form which can be made into a visible image by further transformation.
3. "Ionizing radiation" means gamma rays and X-rays, alpha and beta particles, high speed electrons, neutrons, protons, and other nuclear particles or rays.
4. "Phantom" means, in radiology, a device that simulates the conditions encountered when radiation or radioactive materials are deposited in vivo and which permits a quantitative estimation of its effect.
5. "Screening administrator" means the principal business officer responsible for the health screening entity.
6. "Screening entity" means the organization providing the health screening procedure.
7. "Screening test" means a procedure which is used for detecting diseases and conditions to aid the determination of the need for medical services.
8. "Test site" means any facility or site, public or private, which analyzes the human body or materials derived from the human body for the purposes of health care, treatment, or screening.
9. "Test-site supervisor" means a person, designated in writing by the director of the screening entity, who is responsible for the health screenings service at the test site.

Historical Note

Adopted effective December 2, 1993 (Supp. 93-4).

R9-14-702. Exemptions

A. A test site is exempt from this Article if it is:

1. A facility, site, or a residence where a test, approved for personal home use by the Food and Drug Administration, is used by an individual without direct supervision or guidance and where this test is not part of a commercial transaction; or
2. A facility or site performing tests solely for forensic purposes.
3. A licensed Arizona physician's office, outpatient facility in a fixed location, or a hospital licensed pursuant to A.R.S. Title 36, Chapter 4.

B. Blood pressure screenings are exempt from this Article.

C. Licensed clinical laboratories performing screening testing are exempt from R9-14-703(A).

Historical Note

Adopted effective December 2, 1993 (Supp. 93-4).

R9-14-703. Registration

A. Prior to performing any health screening testing, and annually thereafter, the screening entity shall submit a registration form prescribed by the Department which shall include the following:

1. Name and street address of the screening entity,
2. Name of the persons owning the screening entity and/or directing the entity,
3. Description of the characteristics of each screening procedure to be performed, and
4. Description of the training program and personnel qualifications for persons to perform each type of screening test.

B. Upon request, the screening entity shall submit to the Department:

1. Name of the business, address, and location where the screening tests will take place; and
2. Name and address of the health care provider and the screening administrator under whose direction the screening testing will be conducted.

C. For each radiography screening rest, the screening entity shall comply with subsections (A) and (B) and, upon request by the Department, include the following:

1. Name of the disease and condition for which the radiographic screening is to be used in diagnosis;
2. Description of the population to be examined in the radiography screenings, including age, sex, physical condition, and other clinical information relevant to the interpretation of the radiographic screenings; and
3. Name and address of the physician interpreting the radiograph.

Historical Note

Adopted effective December 2, 1993 (Supp. 93-4).

R9-14-704. General Personnel Requirements

A. The screening entity shall establish and document the completion of a training program that qualifies personnel through the testing of blind samples, education, orientation, and in-service training that is specific to their responsibilities and within the scope of the screening service, before the health screening takes place.

B. The test-site supervisor shall be responsible for:

1. Overall technical supervision and management of the test site personnel;
2. Maintenance of the quality assurance program;
3. On-site supervision of screening testing; and
4. Providing a person who has participated in an American Red Cross first-aid course or similar course and is trained

in first aid including cardiopulmonary resuscitation, fainting, and anxiety reactions.

C. The screening entity shall have counselors who advise and evaluate results for clients of screening tests for the examination of secretions, body fluids, or excretions of the human body. Each counselor shall complete a training program that includes the following:
1. Delivery of accurate and appropriate information about the screening test,
2. Theory and operation of the testing being performed,
3. Normal result ranges,
4. Explanation of the implications of abnormal values, and
5. Available options for medical follow-up.

Historical Note
Adopted effective December 2, 1993 (Supp. 93-4).

R9-14-705. Personnel Requirements for Radiography Screenings

A. The operator of a system using ionizing radiation shall be certified by the Medical Radiologic Technology Board of Examiners in Arizona. For mammograms, the operator shall have passed a mammography examination as approved by the Board.

B. The interpreting physician of the radiography screening films shall:
1. Be certified by the American Board of Radiology or by the American Osteopathic Board of Radiology or be a resident in radiology and shall comply with one of the following:
   a. For mammograms, continues to read the results of an average of ten or more mammography screening radiograph procedures per week; or
   b. For non-mammography radiographs, continues to read the results of an average of ten or more screening or diagnostic radiograph procedures per week.
2. Prepare and sign a written report of the result of each radiography screening procedure and provide a copy of the written report and the original images or films to the client's screening entity for inclusion in the client's medical record.
3. Provide a written statement of the radiograph result to the client in nontechnical language, either through a referring physician or health care provider or, if not available, directly to the client.

Historical Note
Adopted effective December 2, 1993 (Supp. 93-4).

R9-14-706. General Quality Assurance Standards

A. The screening entity shall have available at the test site the following:
1. Instructions for clients to follow if the screening test requires specific criteria before being tested;
2. Information regarding environmental, dietary, or other factors affecting the test procedures and results of the screening test;
3. A clean work area for testing;
4. Equipment to minimize power surges and, where possible, power interruptions;
5. A safety manual which contains procedures for:
   a. Safe specimen handling.
   b. Disinfection,
   c. Disposal of biohazardous waste,
   d. Employee safety practices,
   e. Client reaction management; and
6. Documentation of compliance with the safety manual.

B. When a screening test is performed by a non-physician, the screening entity shall maintain on-site a quality control program manual which assures the accuracy and uniformity of outcome and which contains the following:
1. Screening test method descriptions,
2. Requirements for the maintenance of instruments and equipment,
3. Procedures for reporting test results, and
4. Quality control criteria for the acceptance of test results.

Historical Note
Adopted effective December 2, 1993 (Supp. 93-4).

R9-14-707. Quality Assurance Standards for Radiography Screenings

A. The screening entity performing radiography screenings shall maintain a quality assurance manual which contains the following:
1. Detailed description of the X-ray examination to be performed for each screening test,
2. Copy of the technique chart for each X-ray examination procedure, and
3. Description of the diagnostic film quality control program.

B. Radiological equipment shall be maintained as follows:
1. X-ray systems for mammography screenings shall be dedicated strictly to the mammography screening procedure, and
2. X-ray equipment registration and evaluations shall be conducted pursuant to A.A.C. R12-1-201 through R12-1-207 and R12-1-602 through R12-1-613.

C. Calibration of equipment for all variable parameters shall be documented whenever the following situations occur:
1. Equipment is installed,
2. Major changes of parameters are made or parts are replaced,
3. Quality assurance tests indicate calibration is needed, and
4. Other times to assure that no more than a year elapses between calibrations.

D. The screening entity shall monitor the performance of the radiography screening system pursuant to A.A.C. R12-1-604 and as follows:
1. Image quality shall be monitored monthly with a phantom and every time the unit is moved or altered. The phantom image shall be retained on site; and
2. For mammography, processor performance and the use of KV-target-filter combination appropriate to the image receptor, using sensitometric strips, shall be monitored daily before patient irradiation and stored at the site of the X-ray machine and shall be immediately accessible for inspection.

E. The radiography screening entity shall maintain a safety manual which shall include the following:
1. Equipment and operating procedures which are free of hazards and provide minimum radiation exposure to patients, personnel, and other persons in the immediate environment;
2. Requirements for shielding of patients, personnel, and facilities which comply with the requirements of A.A.C. R12-1-603(C) and R12-1-607(B) and (C);
3. Monitoring procedures for personnel which comply with the requirements of A.A.C. R12-1-410;
4. Requirements for biennial inspection of equipment by a radiation regulatory officer or health physicist, and
5. Requirements specifying that equipment shall be shockproof, grounded, and UL approved.

Historical Note
Adopted effective December 2, 1993 (Supp. 93-4).

R9-14-708. Records

A. The screening entity shall maintain screening records, except for the radiography screening records referenced in subsection (B), for two years, which shall contain the following:
1. The screening test date, patient name, test site, test results, time, and identification of the person performing each test; and
2. Quality control and quality assurance results and information.

B. The screening entity shall maintain, for five years, radiography screening records which shall contain the following:
1. Name of the client,
2. Date each screening test was performed and the date of the interpretation,
3. Name of the operator of the equipment and the name of the interpreting physician,
4. Description of the screening test performed,
5. Name of the health care provider identified by the patient to receive the interpreting physician's written report,
6. Copy of the interpreting physician's written report,
7. Date the interpreting physician's written report was sent to the client's health care provider or the client, and
8. Quality control and quality assurance results and information.

C. The screening entity shall retain mammography images indefinitely.

D. The screening entity shall retain other radiography images for five years.

E. If the screening entity terminates its operation before the required retention periods cited in this Section, all screening records shall be returned to the referring physician, health care provider, or the client.

Historical Note
Adopted effective December 2, 1993 (Supp. 93-4).

R9-14-709. Reporting Results and Follow-up

A. The client's test report shall contain the following:
1. Name, address, and telephone number of the screening entity;
2. Statement that testing was for screening purposes, was not for diagnostic purposes, and consultation with a physician or health care provider may be necessary; and
3. If clinical laboratory tests were performed, the name of the clinical laboratory, the address, the director's name, and the physician requesting testing, if other than the director.

B. Abnormal screening test results shall be reported to the physician who requested the testing or the client's health care provider. In the absence of the physician or the provider or, in those cases where the test results were normal, the screening entity shall provide the following to the client:
1. Copy of the test report;
2. Confidential counseling and educational information, specific to the screening test performed, to aid their understanding of the results of the screening test; and
3. Method of follow-up for the client with abnormal results.

C. The radiography screening entity shall issue a report of the normal or abnormal result to the client's health care provider or, if not available, directly to the client.

Historical Note
Adopted effective December 2, 1993 (Supp. 93-4).

TITLE 9. HEALTH SERVICES

CHAPTER 15. DEPARTMENT OF HEALTH SERVICES MENTAL HEALTH SERVICES

Editor's Note: Sections R9-15-102 through R9-15-117 were repealed effective October 1, 1992; filed with the Office of the Secretary of State October 14, 1992, under an exemption from the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6), pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council; the Department was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is being printed on blue paper. For the text of the rules which were repealed through this exemption, please refer to Supp. 89-4.

ARTICLE 1. REPEALED

Article 1 consisting of Sections R9-15-101 through R9-15-114 adopted effective November 16, 1983.

Former Article 1 consisting of Sections R9-15-101 through R9-15-117 repealed effective November 16, 1983.

Sections R9-15-102 through R9-15-104 repealed and new Section R9-15-102 adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6).

Section

R9-15-101. Repealed
R9-15-102. Repealed
R9-15-103. Repealed
R9-15-104. Repealed
R9-15-105. Repealed
R9-15-106. Repealed
R9-15-107. Repealed
R9-15-108. Repealed
R9-15-109. Repealed
R9-15-110. Repealed
R9-15-111. Repealed
R9-15-112. Repealed
R9-15-113. Repealed
R9-15-114. Repealed
R9-15-115. Repealed
R9-15-116. Repealed
R9-15-117. Repealed
Appendix A. Repealed
Appendix B. Repealed
Appendix C. Repealed
Appendix D. Repealed
Appendix E. Repealed
Appendix F. Repealed
Appendix G. Repealed
Appendix H. Repealed
Appendix I. Repealed
Appendix J. Repealed

ARTICLE 2. REPEALED

Sections R9-15-211 through R9-15-230 repealed effective February 7, 1995 (Supp. 95-1).

Section

R9-15-201. Reserved
R9-15-202. Reserved
R9-15-203. Reserved
R9-15-204. Reserved
R9-15-205. Reserved
R9-15-206. Reserved
R9-15-207. Reserved
R9-15-208. Reserved
R9-15-209. Reserved
R9-15-210. Reserved
R9-15-211. Repealed
R9-15-212. Repealed
R9-15-213. Repealed
R9-15-214. Repealed
R9-15-215. Repealed
R9-15-216. Repealed
R9-15-217. Repealed
R9-15-218. Repealed
R9-15-219. Repealed
R9-15-220. Repealed
R9-15-221. Repealed
R9-15-222. Repealed
R9-15-223. Repealed
R9-15-224. Repealed
R9-15-225. Repealed
R9-15-226. Repealed
R9-15-227. Repealed
R9-15-228. Repealed
R9-15-229. Repealed
R9-15-230. Repealed

ARTICLE 3. REPEALED

Former Article 3 consisting of Sections R9-15-301 through R9-15-313 repealed effective November 16, 1983 (Supp. 83-6).

ARTICLE 1. REPEALED

R9-15-101. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-102. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Section R9-15-102 repealed by emergency, new Section R9-15-102 adopted as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Repealed effective December 22, 1989 (Supp. 89-4). Repealed again under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

R9-15-103. Repealed

Historical Note

Adopted effective November 16, 1983. Repealed as an emergency effective November 17, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired, original text placed back into effect.. (Supp. 89-1). Subsections (A) and (B) amended as an emergency effective March 23, 1989, pursuant to A.R.S.

§ 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Subsections (A) and (B) readopted and Subsections (E) and (F) amended as an emergency effective June 26, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Repealed effective December 22, 1989 (Supp. 89-4). Repealed again under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

R9-15-104. Repealed

Historical Note

Adopted effective November 16, 1983. Repealed as an emergency effective November 17, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Subsections (A) and (B) amended as an emergency effective March 23, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. See emergency adoption below (Supp. 89-2). Subsections (A) and (B) amended as an emergency effective March 23, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Subsections (A) and (B) readopted and Subsections (E) and (G) amended as an emergency effective June 26, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Repealed effective December 22, 1989 (Supp. 89-4). Repealed again under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

R9-15-105. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Repealed under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

R9-15-106. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Repealed under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

R9-15-107. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Repealed under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

R9-15-108. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Repealed under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

R9-15-109. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Repealed under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

R9-15-110. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Repealed under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

R9-15-111. Repealed

Historical Note

Former Section R9-15-111 repealed, new Section R9-15-111 adopted effective November 16, 1983 (Supp. 83-6). Repealed under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

R9-15-112. Repealed

Historical Note

Former Section R9-15-112 repealed, new Section R9-15-112 adopted effective November 16, 1983 (Supp. 83-6). Repealed under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

R9-15-113. Repealed

Historical Note

Former Section R9-15-113 repealed, new Section R9-15-113 adopted effective November 16, 1983 (Supp. 83-6). Repealed under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

R9-15-114. Repealed

Historical Note

Former Section R9-15-114 repealed, new Section R9-15-114 adopted effective November 16, 1983 (Supp. 83-6). Repealed under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

R9-15-115. Repealed

Historical Note

Repealed effective November 16, 1983 (Supp. 83-6). Repealed again under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

R9-15-116. Repealed

Historical Note

Repealed effective November 16, 1983 (Supp. 83-6). Repealed again under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

R9-15-117. Repealed

Historical Note

Repealed effective November 16, 1983 (Supp. 83-6). Repealed again under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

APPENDIX A. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Repealed again under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

APPENDIX B. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Repealed again under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

APPENDIX C. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Repealed again under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

APPENDIX D. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Repealed again under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

APPENDIX E. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Repealed again under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

APPENDIX F. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Repealed again under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

APPENDIX G. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Repealed again under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

APPENDIX H. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Repealed again under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

APPENDIX I. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Repealed again under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

APPENDIX J. Repealed

Historical Note

Adopted effective November 16, 1983 (Supp. 83-6). Repealed again under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61 effective October 1, 1992, filed October 14, 1992 (Supp. 92-4).

ARTICLE 2. REPEALED

R9-15-201. Reserved

R9-15-202. Reserved

R9-15-203. Reserved

R9-15-204. Reserved

R9-15-205. Reserved

R9-15-206. Reserved

R9-15-207. Reserved

R9-15-208. Reserved

R9-15-209. Reserved

R9-15-210. Reserved

R9-15-211. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-212. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-213. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-214. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-215. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-216. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-217. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-218. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-219. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-220. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-221. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-222. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-223. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-224. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-225. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-226. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-227. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-228. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-229. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

R9-15-230. Repealed

Historical Note

Repealed effective February 7, 1995 (Supp. 95-1).

ARTICLE 3. REPEALED

Former Article 3 consisting of Sections R9-15-301 through R9-15-313 repealed effective November 16, 1983 (Supp. 83-6).

TITLE 9. HEALTH SERVICES

CHAPTER 16. DEPARTMENT OF HEALTH SERVICES OCCUPATIONAL LICENSING

ARTICLE 1. LICENSING OF MIDWIFERY

Article 1, consisting of Sections R9-16-101 through R9-16-112 and Exhibits A through E, adopted effective as noted in Section Historical Notes (Supp. 94-1).

Section
R9-16-101. Definitions
R9-16-102. Qualifications for Licensure
Exhibit A. Intent to Apprentice in Midwifery
R9-16-103. Application for Licensure
Exhibit B. Midwifery License Application Form
Exhibit C. Preceptor Rating Guide
R9-16-104. Qualifying Examination
R9-16-105. Initial License Fee; Renewal; Continuing Education
Exhibit D. Renewal Application Form
R9-16-106. Responsibilities of the Licensed Midwife
R9-16-107. Recordkeeping and Report Requirements
Exhibit E. Individual Quarterly Report
R9-16-108. Prohibited Practice; Transfer of Care
R9-16-109. Required Consultation
R9-16-110. Emergency Measures
R9-16-111. Denial, Suspension, or Revocation of License; Civil Penalties; Procedures
R9-16-112. Reinstatement After Suspension

ARTICLE 2. REPEALED

Article 2, consisting of Sections R9-16-201 through R9-16-207 and R9-16-211 through R9-16-214, repealed effective March 14, 1994 (Supp. 94-1).

ARTICLE 3. LICENSING HEARING AID DISPENSERS

Article 3, consisting of Sections R9-16-301 through R9-16-314, adopted effective June 25, 1993 (Supp. 93-1).

Article 3, consisting of Sections R9-16-301 through R9-16-305, repealed effective June 25, 1993 (Supp. 93-1).

Section
R9-16-301. Definitions
R9-16-302. Appointed Committees
R9-16-303. Licensure Processes
R9-16-304. Sponsors
R9-16-305. Examination for Licensure
R9-16-306. Structure of the Examination
R9-16-307. Regular License Renewal
R9-16-308. Continuing Education Licensure Requirements
R9-16-309. Continuing Education Course Requirements
R9-16-310. Waiver of Continuing Education Requirements
R9-16-311. Dispenser Operating Guidelines
R9-16-312. Inspection Requirements
R9-16-313. Complaint Procedure
R9-16-314. Enforcement Actions

ARTICLE 4. REGISTRATION OF SANITARIANS

Section
R9-16-401. Legal authority
R9-16-402. Definitions
R9-16-403. Reserved
R9-16-404. Reserved
R9-16-405. Reciprocity
R9-16-406. Application for registration
R9-16-407. Fees
R9-16-408. Examination
R9-16-409. Registered sanitarian; examples of duties
R9-16-410. Denial or application for registration
R9-16-411. Suspension and revocation of registration
R9-16-412. Re-registration
R9-16-413. Continuing education
R9-16-414. Violations

ARTICLE 1. LICENSING OF MIDWIFERY

R9-16-101. Definitions

In Article 1, unless the context otherwise requires:

1. "Abnormal presentation" means the fetus is not in a head down position with the crown of the head being the leading body part.
2. "ABO" means the classification of blood types.
3. "ADHS" or "Department" mean the Arizona Department of Health Services.
4. "Amniotic" means the fluid surrounding the fetus while in the mother's uterus.
5. "Apgar score" means the numerical score assigned to a newborn's physical condition at birth based on a rating of zero to two given to selected body functions.
6.. "Apprenticeship" means the period of time, under the direction of a preceptor, during which a student obtains all of the necessary theoretical, clinical, and practical application and intervention skills and knowledge required to be licensed pursuant to these rules.
7. "Aseptic" means free of germs.
8. "Cervix" means the narrow lower end of the uterus which protrudes into the cavity of the vagina.
9. "Consultation" means communication between a licensed midwife and physician for the purpose of receiving and implementing prospective advice regarding the care of a pregnant woman or infant.
10. "Core subjects" means the portion of study related to a woman's reproductive cycle and fetal/infant development including: human anatomy and physiology, embryology, biology, genetics, pharmacology, psychology and nutrition.
11. "Dilation" means opening of the cervix during the mechanism of labor to allow for passage of the fetus.
12. "Direction" means the advice provided by a preceptor to a student to assist in making changes in performance without necessarily being in attendance.
13. "Effacement" means the gradual thinning of the cervix during the mechanism of labor and indicates progress in labor.
14. "Episiotomy" means the cutting of the perineum, center, middle, or midline, in order to enlarge the vaginal opening for delivery.
15. "Fetus" refers to the infant in the mother's uterus.
16. "HIV+" means a positive test for the Human Immunodeficiency Virus.
17. "Infant" means a human being between birth and two years of age.
18. "Informed Consent" means a document signed by a client consenting to the provision of midwifery services, following receipt of information and education from a licensed midwife in accordance with R9-16-106(D).

19. "Intrapartum" means occurring from the onset of labor until after the delivery of the placenta.
20. "Ketones" means certain harmful chemical elements which are present in the body in excessive amounts when there is a compromised bodily function.
21. "Local registrar" means a person appointed by the state's registrar of vital statistics for a registration district whose duty includes receipt of birth and death certificates for births and deaths occurring within that district for review, registration, and transmittal to the state office of vital records in accordance with A.R.S. Title 36, Chapter 3.
22. "Low risk" means that the expected outcome of pregnancy, determined through physical assessment and review of the obstetrical history shall most likely be that of a healthy woman giving birth to a healthy infant and expelling an intact placenta.
23. "Meconium" means the first bowel movement of the newborn, which is greenish black in color and tarry in consistency.
24. "Multipara" means a woman who has given birth more than once.
25. "Newborn" means an infant who is within the first 28 days of life.
26. "Observation" means the planned learning experience where the student midwife obtains knowledge through watching a licensed, registered, or certified midwife, or certified nurse midwife or physician provide obstetric service to a mother or newborn.
27. "Parity" means the number of infants a woman has delivered.
28. "Perineum" means the muscular region in the female between the vaginal opening and the anus.
29. "Physician" means a medical, osteopathic, or naturopathic practitioner licensed pursuant to A.R.S. Title 32, Chapters 13, 14, and 17, who has an obstetric practice.
30. "Postpartum" means the six-week period following delivery of an infant and placenta.
31. "Preceptor" means an Arizona-licensed midwife, certified nurse-midwife, physician, or a midwife who is certified, registered, or licensed by another state and who is responsible for supervising a person preparing to be licensed as a midwife during the person's apprenticeship period.
32. "Prenatal" means the period from conception to the onset of labor and birth.
33. "Prenatal care" means the on-going risk assessments, clinical examinations, and prenatal, nutritional, and anticipatory guidance offered to a pregnant woman.
34. "Prenatal visit" means each clinical examination of a pregnant woman for the purpose of monitoring the course of the pregnancy and the overall health of the woman.
35. "Primigravida" means a woman who is pregnant for the first time.
36. "Primipara" means a woman who has given birth to her first infant.
37. "Quickening" means the first perceptible movement of the fetus in the uterus, appearing usually in the 16th to the 20th week of pregnancy.
38. "Rh" means a blood antigen.
39. "Shoulder dystocia" means the shoulders of the fetus are wedged in the mother's pelvis in such a way that the fetus is unable to be born without emergency action by the midwife.
40. "Supervision" means, in a preceptor-student midwife relationship, overseeing a student's learning activities while retaining full responsibility for the care of the client and being present during new procedures.
41. "Transfer of care" means that the midwife refers the care of the client to a medical facility or physician who then assumes responsibility for the direct care of the client.
42. "Universal precautions" means the handling of all materials and instruments which may contain or have been in contact with blood or bodily fluids in accordance with the "Update: Universal Precautions for the Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and other Bloodborne Pathogens in Health Care Settings," *Morbidity and Mortality Weekly Report*, June 24, 1988, Vol. 37, No. 24, Centers for Disease Control, 1600 Clifton Road, N.E., Atlanta, GA 30333, incorporated herein by reference and on file with the Office of the Secretary of State.

Historical Note
Section repealed, new Section adopted effective March 14, 1994 (Supp. 94-1).

R9-16-102. Qualifications for Licensure

To qualify for a midwife license, an applicant shall:

1. Be 18 years of age or older;
2. Be a graduate from high school or the equivalent;
3. Be currently certified by the American Heart Association in adult basic cardiopulmonary resuscitation (CPR) and by the American Academy of Pediatrics in neonatal resuscitation.
4. Submit the "Intent to Apprentice in Midwifery" form set forth in Exhibit A to the Department and complete a midwifery apprenticeship within five years prior to the date of application for licensure.
5. If licensed to practice midwifery in another state, in addition to complying with paragraphs (1), (2), (3), (6), and (7):
   a. Provide evidence of either completion of a midwifery apprenticeship program or state-licensed and professionally approved school at least equivalent to R9-16-103(E), (F), and (G). This shall be done in lieu of R9-16-103(E), (F), and (G).
   b. If the above is not completed within five years prior to the date of application for Arizona licensure, the midwife shall, in addition to the requirements of R9-16-102(5)(a), demonstrate experience in the management of prenatal, intrapartum, postpartum, and newborn periods, including not less than 50 labor and deliveries within the five years prior to application for Arizona licensure, as evidenced by letters from licensed physicians in that state who have provided services to the midwife's clients.
6. Submit to the Director one written recommendation from a physician, certified nurse-midwife, or a licensed midwife, and one written recommendation from a client of midwifery services; and
7. Submit to a background search conducted by the Department and the Office of Special Investigations for purposes of determining if the applicant has ever been convicted of a felony or misdemeanor involving moral turpitude.

Historical Note
Section repealed, new Section adopted effective March 14, 1994 (Supp. 94-1).

EXHIBIT A

INTENT TO APPRENTICE IN MIDWIFERY

DIVISION OF FAMILY HEALTH SERVICES

INTENT TO APPRENTICE IN MIDWIFERY

Office Use Only
Date:
Name: Date of Birth:
Address: Phone:
(home)
Phone:
(work)
Preceptor Name: Phone:
(home)
Preceptor Address: Phone:
(work)
Preceptor's Consultants Utilized and Emergency Plan:

Apprenticeship to Begin on: Be Completed By:

I. Education

Institution Location Course of Study Dates Attended Degree or Certification

II. Affidavit

By signing this application, I certify under penalty of law that the information provided anywhere in this application is true, correct, and complete to the best of my knowledge and belief. I have received a copy of the statute and rules governing the practice of licensed midwifery in the State of Arizona. I understand, should any questions arise regarding completion of this application process, that I am responsible for contacting the program manager for clarification. I also acknowledge that, should investigation at any time disclose any misrepresentation or falsification, my application will be denied or my license will be revoked, denied, or suspended.

III. Notarized Signatures

Notary

Apprentice Midwife Date

Notary

Preceptor Date

Expiration Date

Historical Note

Section repealed, new Section adopted effective March 14, 1994 (Supp. 94-1).

R9-16-103. Application for Licensure

A. An applicant for a license to practice midwifery shall submit the following information to the Department on forms prescribed by the Director:
1. A completed application packet with notarized preceptor signature;
2. A filing fee of $25; and
3. A 2x2 photograph of the applicant.

B. A completed application, shown as Exhibit B, including the validation of midwifery apprenticeship signed by the applicant's preceptor, shall be submitted to the Director by an applicant on or before March 15th if an applicant desires to sit for the June administration of the licensing exam, or on or before July 15th if the applicant desires to sit for the fall administration of the examination.

C. All documents required to be submitted in applying for licensure shall be an original or a certified copy of an original.

D. The Director may refuse to consider any application which is not complete. An applicant shall provide a more detailed response to any request by the Director for additional information.

E. Each applicant shall provide evidence of having obtained a score of 80% or better in each of the core subjects from accredited college-level courses, or through self study and demonstration of competencies and knowledge to a preceptor at a level of above average or excellent in each of the core subjects. A preceptor shall utilize the standards in the Preceptor Rating Guide which is set forth in Exhibit C.

F. Each applicant shall provide evidence of having obtained during apprenticeship, under the supervision and direction of a preceptor, an assessment of above average or excellent, based upon the standards in the Preceptor Rating Guide, in each of the following:
1. 60 prenatal care visits to a minimum of 15 women;
2. Attendance at the labor and delivery of at least 25 live births, for the purpose of observation and to provide assistance to the preceptor;
3. Supervised management of labor and delivery of the newborn and placenta for at least 25 births;
4. 25 newborn examinations;
5. 25 postpartum evaluations of mother and newborn within 72 hours and again at six weeks; and
6. Observation of one complete set of at least six prepared childbirth classes offered by a nationally certified childbirth educator or organization.

G. Each applicant shall provide evidence of having obtained during apprenticeship an assessment of above average or excellent, based upon the standards in the Preceptor Rating Guide, from the applicant's preceptor in each of the following:
1. Provision of care during the prenatal, intrapartum, postpartum, and newborn period;
2. Recognition of normal, abnormal, emergency, and complications of expected fetal and maternal conditions and the appropriate application of interventions;
3. Practice of universal precautions in the handling of bodily fluids and the aseptic theory related to the provision of care during a woman's childbearing year;
4. Techniques of drawing blood and performing urine testing, ordering exams as well as the interpretation of results;
5. Performing injections;
6. Suturing;
7. Techniques in the operation and maintenance of office laboratory equipment;
8. Techniques of record maintenance and charting; and
9. Techniques of physical assessment in adults and newborns.

H. Applicants determined to be eligible for the exam and, upon being informed of the exam dates and times in writing by the Department, shall submit a $100 testing fee no later than 30 days prior to the date of the examination.

Historical Note
Adopted effective March 14, 1994 (Supp. 94-1).

EXHIBIT B

MIDWIFE APPRENTICESHIP APPLICATION

DIVISION OF FAMILY HEALTH SERVICES

APPLICATION PART I

MIDWIFE APPRENTICESHIP DOCUMENTATION

GENERAL INFORMATION

Office Use: Date:

Name:
Date of Birth:
Address:

Phone: (home) Phone: (work)

ENCLOSE FILING FEE OF $25.00

TESTING FEE IS $100.00

I. Core Subjects: Grade: Study Completed at:

Anatomy & Physiology
Embryology/Genetics
Pharmacology
Psychology
Nutrition

II. Practical experience: Grade: General Experience Grade

Prenatal visits (60) _____ Overall Care _____
Observe birth (10) _____ Recognition & Intervention _____
L & D Management (25)_____ of norm, abnormal & emerg.
Newborn Exams (25)_____ Universal Precautions_____
Postpartum Exam (25)_____Technique of obtaining spec. _____
Childbirth Prep class_____ Techniques of record manage. _____
Physical Assessment Adult & NB_____
(Refer to attached detail)

III. American Heart Association CPR Certification Exp Date

CPR Adult & Infant (Certified copy of card enclosed) _____

IV. Letters of Recommendation

Three letters of recommendation must be mailed directly to the Program Manager from the following individuals: your preceptor, a physician or certified nurse midwife, and a client.

Have you ever been convicted of a felony? Yes No
Have you ever been convicted of a misdemeanor? Yes No
Explanation:

By signing this application, I certify under penalty of law that the information provided anywhere in this application is true, correct and complete to the best of my knowledge and belief. I also acknowledge that, should investigation at any time disclose any misrepresentation or falsification, my license will be revoked, denied, or suspended. I also authorize the Department to make all necessary and appropriate investigations allowable by law to verify the information provided:

Applicant Date
Social Security # _____

DIVISION OF FAMILY HEALTH SERVICES

APPLICATION PART II

VALIDATION OF MIDWIFERY APPRENTICESHIP

Office Use Only

Date:
Name:
Address:
Apprentice time period. Began on: Completed on:
Preceptor Name & Title:
Address: Home Phone:
Work Address: Work Phone:

(Enclose a copy of your current license and circle the expiration date)

By signing this application, I certify under penalty of law that the information provided anywhere in this application is true, correct, and complete to the best of my knowledge and belief. I also acknowledge that, should investigation at any time disclose any misrepresentation or falsification, my license will be revoked, denied, or suspended. I also authorize the Department to make all necessary and appropriate investigations allowable by law to verify the information provided.

Preceptor Signature Date
Notary / Expiration Date Date

Historical Note

Adopted effective March 14, 1994 (Supp. 94-1).

EXHIBIT C

RECEPTOR RATING GUIDE

The following assessment form is provided to act as a guide for the preceptor and student. This guide will act as a standard to measure student strengths and opportunities for improvement.

1 - Excellent: Demonstrates consistently high level of performance using sound scientific principles for practice, able to motivate patient and family in practice, uses consultation, requires minimal supervision.

2 - Above Average: Generally performs with competence but requires periodic supervision, uses consultation appropriately, applies sound scientific principles to practice, protects patient's safety and dignity.

3 - Average: Performs procedures adequately but needs supervision, can answer questions relative to underlying scientific principles, practice more self-centered than client-cen-

tered.

4 - Below Average:Needs considerable supervision, can perform skills if has them demonstrated or reinforced; knows most of the principles underlying procedures but needs help in making application in the situation.

5 - UnacceptableCannot perform skill with even minimal competence, does not know or understand principles underlying the procedures to be performed, practices inappropriately so as to threaten patient's safety, dignity, or comfort. Unable to judge.

Historical Note

Adopted effective March 14, 1994 (Supp. 94-1).

R9-16-104. Qualifying Examination

A. An applicant for midwifery licensure shall take a three-part examination administered sequentially and biannually by the Department and consisting of the following:
1. A written examination designed to test the applicant's knowledge of the theory of pregnancy, childbirth, and the core subjects;
2. An oral examination designed to test clinical judgment in the practice of licensed midwifery; and
3. A practical examination designed to demonstrate the applicant's mastery of skills necessary for the practice of midwifery.

B. All applicants registered for the examination shall provide proof of identity by a photographic identification upon request of the proctor administering the test. The proctor shall take all necessary and appropriate actions to secure the integrity of the examination process and may change an applicant's seating location or, for good cause, exclude an applicant from the examination.

C. An applicant shall score 80% or more correct in an examination part before being permitted to take the next part of the examination.

D. An applicant shall score 80% correct on all parts of the examination to be eligible for licensure.

E. An applicant who fails the examination shall not be required to retake those parts of the examination for which the applicant scored 80% or more correct if the applicant retests within two years of taking the examination.

Historical Note

Adopted effective March 14, 1994 (Supp. 94-1).

R9-16-105. Initial License Fee; Renewal; Continuing Education

A. An applicant who qualifies for initial licensure shall submit a $25 licensing fee.

B. For purposes of renewal of license, each licensee shall, in accordance with A.R.S. § 36-754(C), file the following with the Department:
1. An application for renewal on the form set forth in Exhibit D.
2. A $25 renewal fee.
3. A signed affidavit as evidence of completion of the continuing education requirement, pursuant to subsection (C), for courses which have been approved by either the American Nurses Association, the American College of Obstetrics and Gynecologists, Midwives Alliance of North America, Arizona Medical Association, or the American College of Nurse Midwives.
4. Evidence of current certification by the American Heart Association in cardiopulmonary resuscitation for the adult and by the American Academy of Pediatrics in newborn resuscitation.

C. During the term of a license, a licensed midwife shall obtain ten continuing education units which are related to maintaining the skills and judgment necessary to:
1. Assess a client for acceptance and monitor the client's ongoing condition;
2. Plan and manage care during the normal prenatal, intrapartum, and postpartum periods;
3. Intervene when the client's condition deviates from normal.
4. Provide emergency assistance, as permitted by these rules, until medical care can be obtained;
5. Offer anticipatory guidance and support on an ongoing basis for the client and family including nutritional counseling, substance abuse cessation, encouragement for early and continuous care for mother and infant, and motivate the client to establish a relationship with a primary care provider; and
6. Provide referral services to medical and community services as appropriate for the client's needs.

D. A midwife shall submit a written request and a fee of $10.00 to receive a duplicate license.

Historical Note

Adopted effective March 14, 1994, except for subsections (B)(3) and (C) which are effective September 15, 1994 (Supp. 94-1).

EXHIBIT D. APPLICATION FOR BIENNIAL RENEWAL OF MIDWIFE LICENSE

ARIZONA DEPARTMENT OF HEALTH SERVICES

FAMILY HEALTH SERVICES

WOMEN'S AND CHILDREN'S HEALTH

APPLICATION FOR BIENNIAL RENEWAL OF MIDWIFE LICENSE

1.NAME:2.MIDWIFE LICENSE NUMBER:

LastFirstMiddle

3.SOCIAL SECURITY NUMBER:4. DATE OF BIRTH:

(day/month/year)

5.HOME ADDRESS:

( )

Street AddressArea Code/Telephone Number

Mailing Address (If different from street address)

CityCountyStateZip

6.BUSINESS ADDRESS:

Business Title

( )

Street AddressArea Code/Telephone Number

Mailing Address (If different from street address)

CityCountyStateZip

7.CONSUMER LISTING:

A listing of the licensed midwives is maintained for ADHS use. Consumers and various groups request copies of the listing of licensed midwives. Do you wish to have your name on this list? Yes ___ No ___

If yes, which name, address, and phone number would you like to have on that list?

Name and Business Title

( )

Street or Post Office BoxArea Code/Telephone Number

CityCountyStateZip

8. ATTENDING DELIVERIES:

1)If you do not plan to attend any births during the next licensure period (July 1 to June 30), please complete the following statement. I do not plan to attend any deliveries as a licensed midwife from July 1, ____ to June 30, ____.

Signature:

2)If you do attend births after signing this statement, you must submit quarterly reports.

9.MIDWIFERY PRACTICE:

1)Have you had any maternal deaths during the past licensure period? Yes ____ No ___. If yes, give client name and number.

_____
_____
_____

2)Have you delivered any stillborn infants during the past licensure period? Yes ___ No ___. If yes, give client name and number.

_____
_____
_____

3)Have any of the infants you delivered died within the first 28 days of life? Yes ___ No ___. If yes, give client name and number.

_____
_____
_____

10.Do you have any communicable diseases (i.e., tuberculosis, rubella, hepatitis, etc.)? Yes ___ No ___. If yes, please explain on a separate sheet of paper.

11.Besides your midwifery license, do you hold any other licenses in Arizona as a health care provider (i.e., R.N., E.M.T., N.D., etc?)

Yes ___ No ___.

If yes, what other licenses do you hold? _____
_____

12.Have you been convicted of a felony or a misdemeanor (besides a traffic ticket) during the past licensure period?

Yes ___ No ___. If yes, please explain on a separate sheet of paper.

13.What are the backup facilities you expect to use?

NameAddress

1)Hospitals:

_____
_____
_____
_____
_____

2)Physicians:

_____
_____
_____
_____
_____

3) Other:

_____
_____
_____
_____
_____

I certify that the above information is true, complete and correct.

Signature:_____

Date of Application _____

Attach affidavit of continuing education.

****
****
****

DO NOT WRITE BELOW THIS LINE - OFFICE USE ONLY

Date Renewal Notice Sent _____ Date Renewal Form Returned_____

Application returned on _____ for _____

Date completed application received _____License Renewal Granted:Yes ___ No ___ Other _____

Effective Date of License _____ Application Reviewed by _____

OASpgh:PPMWLIC.w93 7/20 10/89

MIDWIFE LICENSING PROGRAM

AFFIDAVIT OF CONTINUING EDUCATION

(To be attached to application for biennial renewal of license)

A.A.C. R9-16-105(C) requires a licensed midwife to obtain ten continuing education units (CEUs) during the term of a license. A CEU is defined by the approving agency.

Units are acceptable for continuing education when approved by one of the following:

American Nurses Association

American College of Obstetrics and Gynecologists

American Medical Association

Midwives Alliance of North America

American College of Nurse Midwives

COMPLETE THE FOLLOWING:

NAME:ADDRESS:

CITY/STATE/ZIP

_____#____
___

TITLE	SPONSOR/AGENCY	DATE	CITY/STATE	CEUs/

HOURS

I hereby swear or affirm that the information given on this form is accurate and complete, and that I have maintained records as evidence of compliance.

SIGNATUREDATE

Subscribed and sworn to before me this _____ day of _____, 19___.

NOTARY PUBLIC

My commission Expires:_____

Historical Note
Adopted effective March 14, 1994 (Supp. 94-1).

R9-16-106. Responsibilities of the Licensed Midwife

A. A midwife shall provide care only to clients determined to be low risk.

B. A midwife shall maintain all instruments used for delivery in an aseptic manner and other birthing equipment and supplies in clean and good condition.

C. A midwife shall both initially and periodically thereafter assess a client's physical condition in order to establish the client's continuing eligibility to receive midwifery services.

D. A midwife shall inform clients, both orally and in writing, of the midwife's scope of practice; the risks and benefits of home birth; the required tests and potential risks to a newborn if refused, and the need for written documentation of client's refusal; the use of a physician or medical facility for the provision of emergency consultation or services; midwife facilitation of the transfer of care to the physician or medical facility; and the midwife's termination of care should certain medical conditions arise or the client refuses intervention. A written informed consent shall be signed by the client upon acceptance for midwifery care.

E. Initial care and care during the prenatal period shall be provided as follows:

1. The following tests shall be scheduled or ordered during the first visit:
   a. Blood type, including ABO and Rh, with antibody screen;
   b. Urinalysis;
   c. Hematocrit, hemoglobin, or complete blood count, initially and rechecked at 28 to 36 weeks of the pregnancy;
   d. Syphilis, gonorrhea, and chlamydia testing, unless a written refusal for gonorrhea or chlamydia testing is obtained from the client;
   e. Rubella titer; and
   f. One-hour blood glucose screening test for diabetes, between 24 to 28 weeks of the pregnancy.
2. Prenatal visits shall be conducted at least every four weeks until 28 weeks gestation, every two weeks from 28 weeks until 36 weeks gestation, and weekly thereafter, and each shall include;
   a. The taking of weight, urinalysis for protein, nitrites, glucose and ketones, blood pressure, and assessment of the lower extremities for swelling;
   b. Measurement of the fundal height and listening for fetal heart tones and, later in the pregnancy, feeling the abdomen to determine the position of the fetus;
   c. Referral of a client as appropriate for ultrasound or other studies recommended based upon examination or history;
   d. Recommendation of administration of the drug RhoGam to unsensitized Rh negative mothers after 28 weeks, or any time bleeding or invasive uterine procedures are done, or midwife administration of RhoGam under physician's written orders; and
   e. Fetal movement counts by client beginning at 28 weeks gestation.
3. Fetal heart tones with fetoscope and documentation of first quickening shall begin between 18 and 20 weeks gestation and weekly visits shall be conducted until these signs have occurred. If these signs do not occur by 22 weeks gestation, medical consultation shall be initiated.
4. A visit shall be made to the client's home prior to 35 weeks gestation to ensure that the birthing environment is appropriate for birth and that a working telephone or citizen's band radio is available.

F. Care during the intrapartum period shall be provided as follows:

1. The midwife shall initially determine if the client is in labor and the appropriate course of action to be taken by:
   a. Assessing the interval, duration, intensity, location, and pattern of the contractions;
   b. Determining the condition of the membranes, whether intact, ruptured, and the amount and color of fluid;
   c. Evaluating the presence of bloody show;
   d. Reviewing with the client the need for an adequate fluid intake, relaxation, activity, and emergency management; and
   e. Deciding whether to go to client's home, remain in telephone contact, or arrange for transfer of care or consultation.
2. During labor, the condition of the mother and fetus shall be assessed upon initial contact, every half hour in active labor until completely dilated, and every 15 to 20 minutes during pushing, after the bag of water has ruptured or until the newborn is delivered. Care shall include the following:
   a. Checking of vital signs every two to four hours and an initial physical assessment of the mother;
   b. Assessment of fetal heart tones every 30 minutes in active first stage labor, and every 15 minutes during second stage, following rupture of the amniotic bag or with any significant change in labor patterns;
   c. Periodic assessment of contractions, fetal presentation, dilation, effacement, and position by vaginal examination;
   d. Determination of the progress of active labor for primiparas by determining if dilation occurs at an average of one cm/hr until completely dilated, and a second stage not to exceed two hours;
   e. Determination of a normal progress of active labor for multigravidas by determining if dilation occurs at an average of 1.5 to 2 cm/hr until completely dilated, and a second stage not to exceed one hour;
   f. Maintenance of proper fluid balance for the mother throughout labor as determined by urinary output and monitoring urine for presence of ketones, at least every two hours; and
   g. Assisting in support and comfort measures to the mother and family.
3. After delivery of the newborn, care shall include the following:
   a. Assessment of the newborn at one minute and five minutes to determine the Apgar scores;
   b. Physical assessment of the newborn for any abnormalities;
   c. Inspection of the mother's perineum for lacerations; and
   d. Delivery of the placenta within forty minutes during which time the midwife shall assess for signs of separation, frank or occult bleeding, examine for intactness, and determine the number of umbilical cord vessels.

4. The responsibility of the midwife shall include recognition of and response to any situation requiring immediate intervention.

G. A midwife shall provide the following care during the postpartum period:

1. During the immediate postpartum period of two hours after delivery of the placenta, care of the mother shall include:
   a. Taking of vital signs of the mother with external massage of the uterus and evaluation of bleeding every 15 to 20 minutes for the first hour and every half hour for the second hour;
   b. Assisting the mother to urinate within two hours following the birth;
   c. Evaluating the perineum for tears, bleeding, or blood clots;
   d. Assisting with maternal and infant bonding;
   e. Assisting with initial breast feeding, instructing the mother in the care of the breast, and reviewing potential danger signs, if appropriate;
   f. Providing instruction and support to the family to ensure adequate fluid and nutritional intake, rest, and type of exercise allowed, normal and abnormal bleeding, bladder and bowel function, appropriate baby care, and any danger signals with appropriate emergency phone numbers;
   g. Recommending the drug RhoGam or administering it, under written physician's orders, to an unsensitized Rh-negative mother who delivers an Rh-positive newborn. Administration shall occur not later than 72 hours after birth.
2. During the immediate postpartum period of two hours after delivery of the placenta, care of the newborn shall include:
   a. Perform a newborn physical exam to determine the newborn's gestational age and any abnormalities;
   b. Apply erythromycin optic ointment or other preparation specifically approved by the Director to each of the newborn's eyes in accordance with A.A.C. R9-6-718; and
   c. Recommend or administer Vitamin K under physician's written orders to the newborn. Administration shall occur not later than 72 hours after birth.
3. Any abnormal or emergency situation shall be evaluated and consultation or intervention sought in accordance with these rules.
4. The condition of the mother and newborn shall be re-evaluated between 24 and 72 hours of delivery to determine whether the recovery is following a normal course and shall include:
   a. Assessment of baseline indicators such as the mother's vital signs, bowel and bladder function, bleeding, breasts, feeding of the newborn, sleep/rest cycle, activity with any recommendations for change;
   b. Assessment of baseline indicators of well-being in the newborn such as vital signs, weight, cry, suck and feeding, fontanel, sleeping, bowel and bladder function with documentation of meconium, and any recommendations for changes made to the family;
   c. Submission of blood obtained from a heel stick to the newborn to the Regional Genetic Screening Laboratory, P.O. Box 17123, Denver, Colorado 80217, for metabolic screening for common genetic disorders, within 72 hours of the birth, unless a written refusal is obtained from the client and documented in the newborn's record.
   d. Recommendation to the mother to secure medical follow-up for her newborn; and
   e. Advice on the necessity of family planning interventions for the couple.

H. The midwife shall file a birth certificate with the local registrar within seven days after the birth of the newborn.

Historical Note

Adopted effective March 14, 1994 (Supp. 94-1).

R9-16-107. Recordkeeping and Report Requirements

A. Each midwife shall establish and maintain a record of the care provided and data gathered for each client.

B. Information in the client's record shall be released by the midwife only with the written consent of the client, legal guardian, or as otherwise provided by law.

C. If a client is a minor, informed consent shall be signed by the parent or legal guardian except as provided in A.R.S. § 44-132 and shall be filed in the client's record.

D. A midwife shall make records available to other health care providers engaged in the care and treatment of the client and upon request by the Department for periodic quality review.

E. A midwife shall maintain evidence of medical evaluation and physician visits in the client's record. Such evidence shall consist of either a report signed by the physician, a copy of the medical and physician notes, or other documentation received from the physician or medical provider.

F. A midwife shall enter a date for each entry in the prenatal record and the postpartum record. A date and time shall be recorded for each entry in the labor record. Each entry shall be initialed or signed by the midwife. If initials are used, the midwife shall sign on the same page.

G. Each licensed midwife shall submit a client summary report for each client to the Department. Such reports shall be submitted within 15 days after the close of each quarter on the form set forth as Exhibit E.

H. Each client's record shall contain the following information, as applicable:

1. Client identification sheet, including name, address, date of birth, sex, next of kin, spouse or other designated person, directions to the client's home, telephone number, and marital status;
2. Health history sheet including pre-existing conditions or surgeries, previous pregnancies, physical examination, nutritional status, and a written assessment of risk factors with an intervention plan when risk factors that require termination of the agreement are present;
3. Progress notes of all encounters with the midwife and other health care consultants, in chronological order, documenting any actions, guidance, and consultations, with copies if appropriate;
4. Laboratory and diagnostic reports;
5. Written informed consent which is signed by the client.

Historical Note

Adopted effective March 14, 1994 (Supp. 94-1).

EXHIBIT E. INDIVIDUAL QUARTERLY REPORT

ARIZONA DEPARTMENT OF HEALTH SERVICES

OFFICE OF MATERNAL AND CHILD HEALTH

MIDWIVES QUARTERLY REPORT

MIDWIFE

1. |___|___|___|___|2.|___||___|___|
LIC. NO. QTR. YR.
REPORT PREPARED BYDATE

3.PATIENT:

(LASTFIRSTMAIDEN)

4.D.O.B.|___|___||___|___||___|___|5.|___|___|6.|___|___|___|

MO. DAY YR. AGE PT. NO.

7.REGISTERED:8.E.D.C.9.DELIVERED:

|___|___||___|___||___|___||___|___||___|___||___|___||___|___||___|___|

|___|___|

MO. DAY YR. MO. DAY YR. MO. DAY YR.

10.GRAVIDA: |___|___|11.PARA. TERM: |___|___|PREMATURE: |___|___|

ABORTIONS |___|___| LIVING |___|___|

*12.PREV. HOME BIRTH: YES / NO*13.REASON FOR CHOOSING H.B.:

_____

ANTEPARTUM:14.NO. MIDWIFE VISITS:_____15.NO.

MEDICAL VISITS:_____

MEDICAL VISITS BY:

_____MD/DO/

OTHER:_____

17.DATES OF FIRST AND LAST MEDICAL VISITS:

_____

_____

18.TOTAL WEIGHT GAIN:|___|___| LBS.

FORMAL ARRANGEMENT FOR MEDICAL BACK-UP:

19.PHYSICIAN_____ ,

MD/DO20.HOSPITAL_____

21.MIDWIFE CARE TERMINATED @ |___|___| WKS. GEST.22.REASON

_____

(ENTER CODE NO. FROM BACK)

LABORATORY DATA: (MOST RECENT)

STUDYRESULTWKS. GEST.STUDYRESULTWKS. GEST.

Hemoglobin23.24.Ua/Glucose37. Pos/Neg38.

Hematocrit25.26.Ua/Protein39. Pos/Neg40.

Serology27.Pos/Neg28.*Ua/Ketones41. Pos./Neg42.

*Rubella Titer29.> 1:10/< 1:1030.*Ua/Microscopic43. Pos/Neg44.

Rh Factor31.Pos/Neg32.*G.C. Culture45. Pos/Neg46.

*Antibody33.Pos/Neg34.*47.48.

Titer*49.50.

*Pap Smear35.Class _____36.*51.52.

LABOR/DELIVERY:LOCATION OF:53.LABOR

_____54.DELIVERY:

_____

55.FIRST STAGE|___|___||___|___|56.SECOND STAGE|___|___||___|___|57. THIRD STAGE|___|___||___|___|

HRS. MINS. HRS. MINS.. HRS. MINS.

58.ROM TO DEL:|___|___||___|___|59.E.B.L.|___|___|___|___| ml.

HRS. MINS.

NEWBORN:60.SEX: MALE / FEMALE61.WT.|___|___|___|___| gm.62. LENGTH|___|___| cm.

63.H.C.|___|___| cm.64.EST. GEST. AGE |___|___| WKS.65.SGA / AGA / LGA

APGAR SCORE:66.1 MIN. _____67.5 MINS. _____68.NO. CORD VESSELS |___|

69.EYE PROPHYLAXIS:NO / YES: _____70.DATE OF METABOLIC SCREENING |___|___||___|___||___|___|

(AGENT) MO. DAY YR.

FOLLOWUP:71.RhoGam: YES / NO72.FIRST MIDWIFE VISIT AT:24. HRS. / 24-48 HRS. / 48-72 HRS. / Other: _____

L.M.

73.TOTAL NO. VISITS:_____

74.VISITS BY _____S.M.

OTHER

ROUTINE PHYSICIAN EVALUATION75.MOTHER:YES / NO76.BABY: YES / NO

LIMITATIONS / COMPLICATIONS / CONSULTATIONS / TRANSFER: (FROM INITIAL WORK-UP THROUGH FOLLOW-UP)

77._____ NONE_____ YES: (Detail on back)

*OPTIONAL

ORIGINAL TO ADHS

COPY TO MIDWIFE

MIDWIFE QUARTERLY REPORT

CLIENT CONDITIONS/COMPLICATIONS

Check (v) any of the following conditions/limitations, complications encountered.

Complete a CONSULTATION/TRANSPORT SUMMARY if client or newborn required transport and/or transfer to physician care, or if you have additional information/comments to provide.

INITIAL WORKUPHISTORY OF:HISTORY OF:**CONSULTATION**

1.Age 15-18 Yrs.6.Stillbirth11.Preterm or LBW infants

2.Age > 35 Yrs.7.Neonatal Death(<2500 gms/5 1/2 lbs.)15.Dr. _____

3.Parity > 48.Difficult Dr./12.Infants 4500/gm/10 lbs.

4.Congenital DefectsDepressed Infantor greater16.Date _____

of Reprod. Organs9.Birth trauma to13.Postpartum hemorrhage/

5.Abn. Findings onmother/infanttransfusion17.Approved for home birth:

Physical Exam.10.Pre-eclampsia14.Other: _____YesNo

Eclampsia

ANTEPARTUMCONSULTATION

18.Elevated BP24.Bleeding 1st or29.Elevated Temp.

19.Edema, Hands/face2nd Trimester30.42 Wks. Gestation37.Dr. _____

20.Persistent headaches25.Bleeding 3rd Trim.31.Excessive Vomiting

21.Visual Disturbances26.U.T.I.32.Persistent Ketonuria38.Date _____

22.Seizures27.HGB < 10 gm/or33.Wt. Gain < 10 lb. at Term

23.Severe Abdom. PainHCT < 30%34.Shortness of Breath39.Approved for continued

28.Varicosities, Vulva35.Chest PainMidwife care:

Legs36.Other: _____YesNo

FETUSCONSULTATION

40.Abn. Growth Pattern44.FHT < 10040.Meconium Staining

41.Expos. to Teratogens45.FHT > 16049.Multiple Gestation51.Dr. _____

42.Excessive Activity46.Irreg. FHT50.Other _____

43.Decreased Activity47.Cord. Prolapse52.Date_____

53.Approved for continued

Midwife Care

YesNo

INTRAPARTUMCONSULTATION

54.Bleeding 1st or 2nd Stage62.Prolonged 1st Stage69.Uterine Atony

55.Elevated BP63.Prolonged 2nd Stage70.Laceration, 1577.Dr. _____

56.Elevated Temp.64.Persistent Ketonuria71.Laceration, 25

57.Pres. not Vertex65.Difficult Delivery/72.Laceration, 3578.Date _____

58.Unengaged HeadShoulder Dystocia73.Laceration, 45

59.Premature ROM66.Hemorrhage in 3rd74.Laceration, periurethral79.Time _____

60.Prolonged ROMStg. or w/in 24 hrs.75.Shock

61.Premature Labor67.Retained Placenta76.Other: _____80.

Approved for continued

68.Retained fragmentsMidwife Care

or membranesYesNo

INFANTCONSULTATION

80.APGAR < 5 @ 1 Min.90.Congenital Anomaly100.Jitteriness not resolved

81.APGAR < 7 @ 5 Min.91.Pretermby feeding109.Dr. _____

82.Respiratory Distress92.Post-Term101.Abnormal Temp.

83.O_2 Given93.< 2500 gm/5 1/2 lbs.102.Abn. finding on P.E.110.Date _____

84.Assisted Ventilation94.> 4500 gm/10 lbs.103.No urination in 24 hrs.

85.Cardiac Massage95.SGA104.No Meconium in 24 hrs.111.Time _____

86.Pale/Cyanotic/Gray96.LGA105.Abdominal Distention

87.Meconium Stained97.Flushed/Red106.Jaundice111.Approved for continued

88.Foul Odor98.Abnormal Cord107.Poor FeedingMidwife Care

89.Abn. Head Circ.99.Abnormal Cry108.Other: _____YesNo

POSTPARTUMCONSULTATION

113.Hemorrhage after116.Unable to Void in119.Thrombophlebitis

24 hours6 hours(positive Homan's sign)51.Dr._____

114.Subinvolution117.Urinary Tract Inf.120.Depression

115.Uterine Infection118.Breast Infection121.Other _____52.

Date_____

53.Approved for continued

Midwife Care

YesNo

ARIZONA DEPARTMENT OF HEALTH SERVICES

OFFICE OF MATERNAL AND CHILD HEALTH

MIDWIVES QUARTERLY REPORT

CONSULTATION/TRANSPORT SUMMARY

ORIGINAL COPY TO ADHS - COPY TO MIDWIFE

_____

MIDWIFE

1. /____/____/____/2./___//___/___/

LIC. NO. QTR. YR.

_____3./___/___/___/

PATIENT NAME PT. NO.

NARRATIVE SUMMARY:

DETAILS ON TRANSFER/TRANSPORT AND OUTCOME:4.

REFERENCE NO.

PROBLEM

CALL FOR TRANSPORT:5.DATE/___/___//___/___/ /___/___/6.

TIME /___/___/___/___/

MO. DAY YEAR (MILITARY TIME)

7.PARAMEDICS8.AMBULANCE

TRANSFER:9.TIME/___/___/___/___/

10.VEHICLE:PRIVATE AUTOAMBULANCEOTHER:

11.DESTINATION:PHYSICIAN'S OFFICEHOSPITALOTHER:

12.NAME OF HOSPITAL IF APPLICABLE:

ARRIVAL DISPOSITION:5.DATE/___/___//___/___/ /___/___/6. /___/___/___/___/

MO. DAY YEAR (MILITARY TIME)

15.MOTHER:EVAL/Rx AT PHYS. OFFICEADMITTED TO HOSPITAL

EVAL/Rx AS OUTPATIENT AT HOSPITAL AND RELEASED

16.NEWBORN:EVAL/Rx AT PHYS. OFFICEADMITTED TO HOSPITAL

EVAL/Rx AS OUTPATIENT AT HOSPITAL AND RELEASED

TRANSFERRED TO NICU AT

17.MATERNAL OUTCOME:NORMALABNORMALEXPIRED

18.NEWBORN OUTCOME:NORMALABNORMALEXPIRED

Historical Note

Adopted effective March 14, 1994 (Supp. 94-1).

R9-16-108. Prohibited Practice; Transfer of Care

A. A licensed midwife shall not accept for care and shall not during pregnancy, labor and delivery, and postpartum knowingly continue to provide care to, and shall immediately transfer care of, any women who has or develops any of the following conditions or circumstances:
1. A previous Cesarean section or other known uterine surgery;
2. A history of severe postpartum bleeding, of unknown cause, which required transfusion;
3. Deep vein thrombophlebitis or pulmonary embolism;
4. Insulin-dependent diabetes, hypertension, heart disease, kidney disease, blood disease, Rh disease with positive titers, active tuberculosis, or active syphilis;
5. Active hepatitis or active gonorrhea until treated and recovered, following which midwife care may resume;
6. An unsafe location for delivery;
7. A blood pressure of 140/90 or an increase of 30mm Hg systolic or 15mm Hg diastolic over client's lowest baseline blood pressure for two consecutive readings taken at least six hours apart;
8. A persistent hemoglobin level blow 10g or a hematocrit below 30 during the third trimester;
9. Primary genital herpes simplex infection in the first trimester or has active genital herpes at the onset of labor;
10. A pelvis that will not safety allow a baby to pass through during labor;
11. A severe psychiatric illness evident during assessment of client's preparation for birth, or a history of severe psychiatric illness in the six-month period prior to pregnancy;
12. An addiction to alcohol, narcotics, or other drugs;
13. Prematurity or labor beginning before 36 weeks gestation;
14. Multiple gestation in the current pregnancy;
15. Gestational age greater than 34 weeks with no prior prenatal care;
16. A gestation beyond 42 weeks;
17. Presence of ruptured membranes without onset of labor within 24 hours;
18. Abnormal fetal heart rate of below 120 beats per minute or above 160 beats per minute;
19. Presence of thick meconium, blood-stained amniotic fluid, or abnormal fetal heart tones;
20. A postpartum hemorrhage of greater than 500cc in the current pregnancy;
21. A nonbleeding placenta retained more than 40 minutes; and
22. Expressed wishes of the client or family.

B. A midwife shall not perform any operative procedures except as provided in R9-16-110.

C. A midwife shall not use any artificial, forcible, or mechanical means to assist birth, nor shall the midwife attempt to correct fetal presentations by external or internal movement of the fetus.

D. A midwife shall not administer drugs or medications except as provided in R9-16-110 and R9-16-106(E)(2)(d), (G)(1)(g), and (G)(2)(c).

E. A midwife shall not knowingly continue and shall transfer care of any newborn in whom any of the following conditions are present:
1. Birth weight less than 2000 grams;
2. Pale, blue, or gray color after ten minutes;
3. Excessive edema;
4. Major congenital anomalies; or
5. Respiratory distress.

Historical Note

Adopted effective March 14, 1994 (Supp. 94-1).

R9-16-109. Required Consultation

A. The midwife shall obtain medical consultation to obtain a recommendation for treatment, referral, or transfer of care at the time any client is determined to have any of the following circumstances or conditions during the current pregnancy:
1. Testing positive for HIV;
2. History of seizure disorder;
3. History of stillbirth, premature labor, or parity greater than five;
4. Is younger than 16 years of age or a primigravida older than 40 years of age;
5. Failure to auscultate fetal heart tones by 22 weeks gestational age;
6. Refusal of Rh blood work or treatment;
7. Failure to gain 12 pounds by 30 weeks gestation or gaining more than 8 pounds in any two-week period during pregnancy;
8. Severe, persistent headaches, with visual disturbances, stomach pains, or swelling of the face and hands;
9. Greater than 1+ sugar, ketones, or protein in the urine on two consecutive visits;
10. Excessive vomiting or continued vomiting after 20 weeks gestation;
11. Symptoms of decreased fetal movement;
12. A fever of 100.45 Fahrenheit or 385 Centigrade twice at 24 hours apart;
13. Effacement or dilation of the cervix, greater than a fingertip, accompanied by contractions, prior to 36 weeks gestation;
14. Measurements for fetal growth are not within 2cm of the gestational age;
15. Second degree or greater lacerations of the birth canal;
16. An abnormal progression of labor;
17. An unengaged head at seven centimeters dilation in active labor;
18. An abnormal presentation after 36 weeks;
19. Failure of the uterus to return to normal size in the current postpartum period; or
20. Persistent shortness of breath requiring more than 24 breaths per minute, or breathing which is difficult or painful.

B. A midwife shall obtain medical consultation to obtain a recommendation for treatment, referral, or transfer of care at the

time any newborn demonstrates any of the following conditions:
1. Weight less than 2500 grams or 5 lbs., 8 oz.;
2. Congenital anomalies;
3. An Apgar score less than seven at five minutes;
4. Persistent breathing at a rate of more than 60 breaths per minute;
5. An irregular heartbeat;
6. Persistent poor muscle tone;
7. Less than 36 weeks gestation or greater than 42 weeks gestation by gestational exam;
8. Yellowish-colored skin within 48 hours;
9. Abnormal crying;
10. Meconium staining of the skin;
11. Lethargy, irritability, or poor feeding;
12. Excessively pink coloring over entire body;
13. Failure to urinate or pass meconium in the first 24 hours of life;
14. A hip examination which results in a clicking or incorrect angle;
15. Skin rashes not commonly seen in the newborn; or
16. Temperature persistently above 99.05 or below 97.65 Fahrenheit.

Historical Note
Adopted effective March 14, 1994 (Supp. 94-1).

R9-16-110. Emergency Measures

A. A licensed midwife shall, before the arrival of emergency medical personnel, perform the following procedures only in an emergency situation in which the health and safety of the mother or newborn are determined to be at sufficient risk:
1. Cardiopulmonary resuscitation of the mother or newborn with a bag and mask;
2. Administration of oxygen at no more than 8 liters per minute via mask for the mother and 5 liters per minute for the newborn via neonatal mask;
3. Midline episiotomy to expedite the delivery during fetal distress;
4. Suturing of episiotomy or tearing of the perineum, to stop active bleeding, following administration of local anesthetic, contingent upon physician consultation or standing orders of physician;
5. Release of shoulder dystocia by rotating the shoulders into one of the oblique diameters of the pelvis; and
6. Manual exploration of the uterus for control of severe bleeding.

B. A licensed midwife may administer a maximum does of 20 units of pitocin intramuscularly, in 10-unit dosages each, 30 minutes apart, to a client for the control of postpartum hemorrhage, contingent upon physician consultation or standing orders by a physician, and arrangements for immediate transport of the client to a hospital.

Historical Note
Adopted effective March 14, 1994 (Supp. 94-1).

R9-16-111. Denial, Suspension, or Revocation of License; Civil Penalties; Procedures

A. In addition to those grounds set forth in A.R.S. §§ 36-756 and 13-904(E), the Department may deny, suspend, or revoke a license permanently or for a definite period of time and may assess a civil penalty of $50 for the first offense and $100 for each subsequent offense, for any of the following causes:
1. Failure to maintain the standards of practice and clinical judgment;
2. Practicing under a false name or alias which will interfere with or obstruct the investigative or regulatory process;
3. Practicing under the influence of drugs or alcohol;
4. Falsification of records;
5. Obtaining any fee for midwifery services by fraud or misrepresentation;
6. Permitting another to use the midwife's license; and
7. Failure to submit quarterly reports within 15 days after the close of the quarter.

B. All administrative proceedings shall be conducted in accordance with the Department's rules of practice and procedure, A.A.C. Title 9, Chapter 1, Article 1.

Historical Note
Adopted effective March 14, 1994 (Supp. 94-1).

R9-16-112. Reinstatement After Suspension

A midwife whose license to practice midwifery has been suspended shall automatically be reinstated at termination of the period of suspension as established by the Director if the conditions contained in the order, if any, have been met.

Historical Note
Adopted effective March 14, 1994 (Supp. 94-1).

ARTICLE 2. REPEALED

R9-16-201. Repealed

Historical Note
Former Section R9-16-201 repealed, new Section R9-16-201 adopted effective January 23, 1978 (Supp. 78-1). Repealed effective March 14, 1994 (Supp. 94-1).

R9-16-202. Repealed

Historical Note
Former Section R9-16-202 repealed, new Section R9-16-202 adopted effective January 23, 1978 (Supp. 78-1). Repealed effective March 14, 1994 (Supp. 94-1).

R9-16-203. Repealed

Historical Note
Former Section R9-16-203 repealed, new Section R9-16-203 adopted effective January 23, 1978 (Supp. 78-1). Repealed effective March 14, 1994 (Supp. 94-1).

R9-16-204. Repealed

Historical Note
Former Section R9-16-204 repealed, new Section R9-16-204 adopted effective January 23, 1978 (Supp. 78-1). Repealed effective March 14, 1994 (Supp. 94-1).

R9-16-205. Repealed

Historical Note
Former Section R9-16-205 repealed, new Section R9-16-205 adopted effective January 23, 1978 (Supp. 78-1). Repealed effective March 14, 1994 (Supp. 94-1).

R9-16-206. Repealed

Historical Note
Former Section R9-16-206 repealed, new Section R9-16-206 adopted effective January 23, 1978 (Supp. 78-1). Repealed effective March 14, 1994 (Supp. 94-1).

R9-16-207. Repealed

Historical Note
Former Section R9-16-207 repealed, new Section R9-16-207 adopted effective January 23, 1978 (Supp. 78-1). Repealed effective March 14, 1994 (Supp. 94-1).

R9-16-208. Reserved
R9-16-209. Reserved
R9-16-210. Reserved
R9-16-211. Repealed

Historical Note
Adopted as an emergency effective July 12, 1982, pursuant to A.R.S. § 41-1003, valid for 90 days (Supp. 82-4). Emergency expired. Permanent rule R9-16-211 adopted effective January 14, 1983 (Supp. 83-1). Repealed effective March 14, 1994 (Supp. 94-1).

R9-16-212. Repealed

Historical Note
Adopted as an emergency effective July 12, 1982, pursuant to A.R.S. § 41-1003, valid for 90 days (Supp. 82-4). Emergency expired. Permanent rule R9-16-212 adopted effective January 14, 1983 (Supp. 83-1). Repealed effective March 14, 1994 (Supp. 94-1).

R9-16-213. Repealed

Historical Note
Adopted as an emergency effective July 12, 1982, pursuant to A.R.S. § 41-1003, valid for 90 days (Supp. 82-4). Emergency expired. Permanent rule R9-16-213 adopted effective January 14, 1983 (Supp. 83-1). Repealed effective March 14, 1994 (Supp. 94-1).

R9-16-214. Repealed

Historical Note
Adopted as an emergency effective July 12, 1982, pursuant to A.R.S. § 41-1003, valid for 90 days (Supp. 82-4). Emergency expired. Permanent rule R9-16-214 adopted effective January 14, 1983 (Supp. 83-1). Repealed effective March 14, 1994 (Supp. 94-1).

ARTICLE 3. LICENSING HEARING AID DISPENSERS

R9-16-301. Definitions
In this Article, unless the context otherwise requires, "CE" means continuing education or the on-going process of receiving in-service education and training that directly relates to the practice of fitting and dispensing hearing aids as defined in A.R.S. §36-1901(6).

Historical Note
Section repealed, new Section adopted effective June 25, 1993 (Supp. 93-2).

R9-16-302. Appointed Committees
A. Advisory committee
1. The advisory committee members appointed by the Director pursuant to A.R.S. § 36-1902(A)(1) and (C) shall assist the Director by making recommendations to the Department regarding the following:
   a. Hearing aid dispenser licensing program,
   b. Resolution of any consumer complaint referred to the committee by the Department involving alleged unethical conduct or incompetence by a dispenser,
   c. Hearing aid dispenser licensing examination,
   d. Membership on the examining committee, and
   e. Membership on the advisory committee.
2. Committee members shall serve a three-year term except for the Department's hearing aid dispenser program manager who shall serve as a permanent member of the committee.

B. Examining committee The examining committee members appointed by the Director pursuant to A.R.S. § 36-1902(B)(4) and (D) shall assist the Director as follows:
1. Examine applicants for licensure,
2. Score delegated sections of the examination,
3. Provide testimony at administrative hearings related to the examination for licensure, and
4. Evaluate examination materials and procedures and make recommendations for change to the Department.

Historical Note
Amended effective March 22, 1976 (Supp. 76-2). Section repealed, new Section adopted effective June 25, 1993 (Supp. 93-2).

R9-16-303. Licensure Processes
A. Licensure by examination
1. An applicant for a hearing aid dispenser license shall submit to the Department a nonrefundable $50 application fee and an application form provided by the Department, which contains the following:
   a. Name, home address, and telephone number of the applicant;
   b. Name of employer, business address, and telephone number;
   c. Statement certified under penalty of perjury which shall contain the acknowledgement that the applicant has never been convicted of a criminal offense or a listing of all criminal convictions.
   d. Physician's written statement or health card obtained within 30 days prior to application that declares the applicant is free of contagious or infectious disease;
   e. Proof of a minimum education level as evidenced by a high school diploma or a general education diploma;
   f. Identification of past and current licensure as a hearing aid dispenser in any other state; and
   g. Statement certified under penalty of perjury of any suspension or revocation of a hearing aid dispenser license in any state within the past two years and notification of current ineligibility for licensure in any state due to prior revocation or suspension.
2. An applicant shall file the completed application form with the Department by the 15th day of the month prior to the month of examination. One examination shall be given in August and additional examinations may be given at other times by the Department.
3. The Director shall notify each applicant by certified mail of the status of the applicant's eligibility to take the examination not later than 15 days prior to the examination. Those applicants who have complied with the prerequisites of this subsection shall also be provided the date, time, and place of the examination.
4. The Director shall notify each applicant of the applicant's test results by certified mail within 30 days following the examination.
5. The Director shall issue a regular license to an applicant who passes the examination in accordance with R9-16-305 and submits a $50 license fee to the Department.

6. An applicant who fails an examination may reapply to take the next scheduled exam by completing a new application and submitting a nonrefundable $50 application fee to the Department, except that an applicant failing three consecutive examinations shall be ineligible to reapply for one year.
7. An applicant who is denied licensure based on test results may appeal the decision pursuant to A.R.S. § 41-1065.

B. Licensure by reciprocity

1. An individual desiring to quality for a license by reciprocity shall:
   a. Submit to the Department a $50 nonrefundable application fee and a $50 license fee;
   b. Submit to the Department a completed application form;
   c. Request that the regulatory body responsible for issuing hearing aid licenses in the applicant's state of licensure provide to the Department copies of the following:
      i. Written statement that the individual holds a current hearing aid dispenser license in good standing;
      ii. Statutes and rules pertaining to hearing aid dispensing in that state;
      iii. Application form filed with that state for licensure;
      iv. Written and practical portions of any examination taken by the applicant, or detailed descriptions thereof; and
      v. Applicant's score on each section of the examination and the criteria for passing.
2. The Department shall determine if the information outlined in paragraph (1) indicates the following:
   a. Content of the examination taken by the applicant is substantially the same or superior to the content of the Arizona examination,
   b. Applicant's scores on the written and practical portions of the examination meet or exceed Arizona's passing criteria, and
   c. Meets the requirements for licensure.
3. The Director shall issue a license by reciprocity pursuant to A.R.S. § 36-1922 to the applicant who meets the requirements of this subsection.
4. If the information provided indicates that the applicant does not meet the requirements of this subsection, the Director shall deny the applicant's request for licensure and return the $50 license fee to the applicant. The applicant may file an appeal of the decision pursuant to A.R.S. § 41-1065.

C. Licensure for business organizations

1. A corporation, partnership, trust, association or other organization maintaining an established business address in Arizona and desiring to engage in the practice of fitting and dispensing hearing aids in Arizona shall submit to the Department a nonrefundable $50 application fee, a $50 license fee and an application form provided by the Department, which contains the following:
   a. Name of the organization;
   b. Arizona business name, address, phone number, and title of the individual responsible for the operation of the business organization in Arizona;
   c. Name, address, and phone number of the individual responsible for receiving service of process in Arizona on behalf of the organization;
   d. Name, business phone number, and hearing aid dispenser license number of each dispenser employed by the organization in Arizona; and
   e. Statement under penalty of perjury that the business organization has not had a hearing aid dispensing license revoked or suspended by a state within the past two years and is presently not ineligible for licensure in any state due to prior revocation or suspension.
2. If the information provided indicates that the applicant meets the requirements for licensure, the Director shall issue a license pursuant to A.R.S. § 36-1928.
3. A business desiring to renew the license shall submit the application form outlined in paragraph (1) and a $50 renewal fee. A $10 late fee shall be assessed for a renewal application filed late in accordance with A.R.S. § 36-1927(A).

D. Temporary license

1. An applicant for an initial temporary license shall submit to the Department a nonrefundable $50 application fee and an application form provided by the Department, which contains the following:
   a. Information specified in paragraph (A)(1);
   b. Sponsor's name, business address, telephone number, and license number; and
   c. Sponsor's signature indicating that the sponsor is a licensed dispenser who agrees to train, supervise, and be responsible for the applicant's testing, fitting, and dispensing activities.
2. The Director shall determine whether the applicant meets the minimum requirements for temporary licensure as outlined in paragraph (1) and shall notify the applicant in writing of the Director's decision.
3. The Director shall issue a temporary license to an eligible applicant after the applicant submits to the Department a nonrefundable $50 license fee and proof of sponsorship.
4. A temporary dispenser may renew the license without taking the next regularly scheduled examination.
5. A temporary license shall expire in accordance with A.R.S. § 36-1926(B) or (D).
6. A temporary dispenser shall be allowed one renewal of the license as authorized by A.R.S. § 36-1926(F) by submitting to the Department a nonrefundable $50 renewal fee and a renewal form provided by the Department which contains the following:
   a. Applicant's name, home address, and phone number;
   b. Employer's name, business address, and phone number;
   c. Sponsor's name, business address, telephone number, and license number; and
   d. Sponsor's signature indicating that the sponsor is a licensed dispenser who agrees to train, supervise, and be responsible for the applicant's testing, fitting, and dispensing activities.

Historical Note

The Department of Health Services advises that this rule is preempted by Section 521(a) of the federal Food, Drug and Cosmetic Act (21 U.S.C. 360K). See 21 CFR 808.53, effective November 10, 1980 (Supp. 80-6). Section repealed, new Section adopted effective June 25, 1993 (Supp. 93-2).

R9-16-304. Sponsors

A sponsor of a temporary dispenser shall be responsible for the following:

1. Providing a minimum of 64 hours per month of on-site training and supervision. The supervision shall include coordinating, directing, watching, inspecting, and evaluating the fitting and dispensing activities of the temporary dispenser. The training shall directly relate to the type of training and education needed to pass the licensing examination as described in A.R.S. S 36-1924.
2. Maintaining a record, signed by the temporary dispenser, that details the date, time and content of the training and supervision provided to the temporary dispenser by the sponsor during the sponsorship period. The record shall be maintained and available for inspection by the Department for one year following the end of the sponsorship agreement.
3. When terminating a sponsorship agreement, complying with the following:
   a. Provide a written statement to the temporary dispenser indicating the sponsorship agreement is terminated and that the temporary dispenser shall return the temporary license to the Department, and
   b. Provide a copy of the written statement of termination and documentation that the temporary dispenser received the termination notice to the Department.
4. Complying with the other requirements in A.R.S. § 36-1926.01.

Historical Note

Amended effective March 22, 1976 (Supp. 76-2). The Department of Health Services advises that this rule is preempted by Section 521(a) of the federal Food, Drug and Cosmetic Act (21 U.S.C. 360K). See 21 CFR 808.53, effective November 10, 1980 (Supp. 80-6). Section repealed, new Section adopted effective June 25, 1993 (Supp. 93-2).

R9-16-305. Examination for Licensure

A. An applicant, upon appearing at the examination site, shall present a current driver's license or other government-issued photo identification before the applicant shall be allowed to take the examination.

B. An applicant who fails to arrive for, or is not allowed to take, the examination pursuant to subsection (A) may reapply for the next scheduled examination by submitting all fees and information required in R9-16-303(A).

C. An applicant admitted late for the examination shall be limited to the time remaining to complete the examination.

D. An applicant found cheating shall fail the examination and shall be ineligible to take the examination or renew a hearing aid license for two years.

E. Each applicant shall bring another person who is not taking the examination to the examination to serve as a test subject along with impression material, cotton or foam dam, syringe, otoscope, and packing box to take an impression of the test subject's ear canal for the purpose of fitting a hearing aid. The applicant may bring additional equipment and materials to accomplish this task.

F. Each applicant shall bring to the examination an otoscope, a listening tube, and a screwdriver to evaluate different types and models of hearing aids and to identify the major problem that renders the hearing aid inoperable. The applicant may bring additional equipment to accomplish this task.

G. The successful applicant shall pass a practical and written examination with a combined average score of 75% or above for the two parts of the examination; however, no more than one section of either the practical or the written examination shall have a score under 75%. A rounding procedure shall not be used in determining any score.

Historical Note

Section repealed, new Section adopted effective June 25, 1993 (Supp. 93-2).

R9-16-306. Structure of the Examination

A. The written and practical part of the examination shall be administered on the same day. The practical part shall include the following subjects:
1. Identification of medical aspects or conditions relating to abnormal middle ear problems,
2. Oral exam on pure tone audiometry,
3. Oral exam on speech audiometry,
4. Obtaining air and bone conduction thresholds using simulators,
5. Hearing aid maintenance and service,
6. Selecting a particular hearing aid based on an audiogram review,
7. Determining the effects of different earmold modifications, and
8. Taking an earmold impression.

B. The written part of the examination shall contain the following:
1. Examination booklet provided by the International Hearing Society;
2. Questions on the Arizona Revised Statutes, and Arizona and federal rules; and
3. Questions on the evaluation and rehabilitation services for the hearing impaired in Arizona.

Historical Note

Adopted effective June 25, 1993 (Supp. 93-2).

R9-16-307. Regular License Renewal

A. The dispenser shall submit to the Department, before the license expiration date, the following:
1. Nonrefundable license renewal fee of $50,
2. Confirmation of CE hours as referenced in R9-16-308(C) and (D); and
3. Renewal form provided by the Department which contains the following:
   a. Dispenser's name, address, and phone number;
   b. Employer's name, address, and phone number; and
   c. Dispenser's license number and date of expiration.

B. The Director shall issue a renewal license to a dispenser who complies with the requirements in subsection (A). The renewal license shall be valid for one year after the expiration date of the previous license.

C. A dispenser may renew the license during a 30-day grace period after the expiration date of the license by submitting the information and renewal fee outlined in subsection (A) and a $10 late fee to the Department.

D. If a dispenser fails to apply for license renewal by the end of the 30-day grace period, the license shall become void and nonrenewable and the individual shall no longer be licensed by the Department. The person may apply for a new license.

E. A person who applies for a new license within one year of the expiration date of the license shall not be required to take the licensing examination but shall submit a nonrefundable $50 application fee, a $50 license fee, the information required in R9-16-303(A)(1) and confirmation of CE hours as referenced in R9-16-308(C).

Historical Note
Adopted effective June 25, 1993 (Supp. 93-2).

R9-16-308. Continuing Education Licensure Requirements

A. Each dispenser shall complete eight hours of continuing education approved under R9-16-309 within 12 months of the effective date of the regular license.

B. A CE hour shall contain 60 minutes of actual course work instruction.

C. If the CE course work complies with the preapproved provisions of R9-16-309 (B) or (C), the dispenser shall complete a CE form provided by the Department that contains the information required in paragraphs (D)(1), (2), (3), (7), (8) and (9).

D. A dispenser submitting confirmation of CE hours earned which do not comply with the preapproved provisions of R9-16-309(B) or (C) shall complete the CE form that contains the following information:
1. Name, business address, and license number of the dispenser;
2. Name of the organization providing the course work, date, and location;
3. Specific courses attended;
4. Detailed description of each course's content;
5. Description of each course's educational objectives;
6. Description of each instructor's education, training and experience background;
7. Number of CE hours earned for each course;
8. Statement indicating if the course work was preapproved in accordance with R9-16-309; and
9. Signed statement under penalty of perjury that the dispenser attended the CE course and that all information on the CE form is complete and accurate.

E. The Director shall approve course work that meets the course requirements outlined in R9-16-309(A) . The Director shall notify the dispenser stating whether or not the CE hours have been approved.

F. The Director shall not give a dispenser credit for CE course work which is substantially the same in content to courses utilized to meet the CE requirements within the preceding year.

G. A dispenser who does not complete eight hours of approved CE may be issued a renewal license if the dispenser applies for and obtains a waiver issued by the Director in accordance with R9-16-310.

H. The dispenser shall maintain, for a period of three years, CE receipts, canceled checks, certificates, attendance sheets, or other documentation which establishes completion of the CE requirement. The Department may randomly audit the dispenser's compliance with the CE requirements.

Historical Note
Adopted effective June 25, 1993 (Supp. 93-2).

R9-16-309. Continuing Education Course Requirements

A. For course work to be eligible for preapproval for CE hours, the course content shall directly relate to the practice of fitting and dispensing hearing aids and the educational objectives shall exceed an introductory level of knowledge as it relates to fitting and dispensing hearing aids. The course work shall include advances, within the last five years, in the field as follows:
1. Procedures in the selection and fitting of hearing aids,
2. Pre- and post-fitting management of clients,
3. Instrument circuitry and acoustic performance data,
4. Earmold design and modification contributing to improved client performance,
5. Audiometric equipment or testing techniques which demonstrate an improved ability to identify and evaluate hearing loss,
6. Auditory rehabilitation,
7. Ethics,
8. Federal and state statutes or rules, or
9. Assistive listening devices

B. Course work that meets the requirements of subsection (A) and is endorsed or sponsored by the following organizations shall be deemed preapproved for CE hours:
1. Arizona Hearing Aid Society,
2. Arizona Speech-Language-Hearing Association,
3. American Speech-Language-Hearing Association,
4. International Hearing Society,
5. National Institute of Hearing Instrument Studies,
6. National Society of Hearing Professionals,
7. American Academy of Audiology,
8. Academy of Dispensing Audiologists,
9. Arizona Society of Otolaryngology-Head and Neck Surgery, or
10. American Academy of Otolaryngology-Head and Neck Surgery.

C. The Director shall preapprove other CE course work that complies with subsection (A) upon the following:
1. The organization providing the course work shall submit the following information 45 days before the course is offered:
   a. Name, date, and location of the CE course work;
   b. Detailed description of the course content;
   c. Description of the educational objectives;
   d. Description of each instructor's education, training, and experience background; and
   e. CE hours offered for completing the course.
2. The provider shall report any change in the course content or instructor to the Department before the course begins.

D. The Director shall withdraw the approval of any CE provider for failure to comply with the provisions of this section.

Historical Note
Adopted effective June 25, 1993 (Supp. 93-2).

R9-16-310. Waiver of Continuing Education Requirements

A. The Director may temporarily waive the CE requirement for any dispenser who, for reasons of health, disability, overseas military service, or undue hardship, cannot meet the requirements.

B. An application for a waiver shall be submitted to the Department on a waiver form provided by the Department which contains the following:
1. Dispenser's name, address, and phone number;
2. Employer's name, address, and phone number;
3. Dispenser's license number and date of expiration;
4. Statement signed by the dispenser under penalty of perjury that the dispenser was unable to obtain the CE hours during the effective period of the license and verified by an attached statement signed by one of the following persons:
   a. Physician licensed in Arizona providing evidence of a mental or physical disability or health problem that has precluded the dispenser from meeting the CE requirement,
   b. Dispenser's superior officer documenting that the dispenser has been involved in overseas military duty, or
   c. Third party that supports an undue hardship claim.

C. Temporary waivers shall be valid for one year, beginning the day after the license expires.

D. If a temporary waiver is granted, the dispenser shall make up all CE deficiencies within the following year as well as complete the requisite CE hours for that year.

Historical Note
Adopted effective June 25, 1993 (Supp. 93-2).

R9-16-311. Dispenser Operating Guidelines

A. A dispenser shall conduct audiometric tests, before selecting a hearing aid for a prospective user, that provide detailed information about the client's hearing loss as follows:
1. Type, degree, and configuration of hearing loss;
2. Ability, as measured by the percentage of words the client is able to repeat correctly, to discriminate speech; and
3. Client's most comfortable and uncomfortable loudness levels in decibels.

B. Audiometric testing may be excluded prior to selling a client a hearing aid if the client presents to the dispenser the information outlined in subsection (A) which was obtained within the last 12 months for an adult or within the last 6 months for a person under the age of 18.

C. Audiometric tests listed in subsection (A) that cannot be performed due to the young age or mental or physical disability of the client may be excluded; however, documentation shall be maintained by the dispenser for three years that supports the exclusion of the specific audiometric tests.

D. Prior to any hearing aid sale, the dispenser shall evaluate the performance characteristics of the hearing aid for the purpose of assessing the degree of benefit to the client.

E. Prior to any hearing aid sale, the dispenser shall follow the requirements contained in 21 CFR 801.420 and 801.421, April 1, 1989, and no further amendments, incorporated herein by reference and on file with the Office of the Secretary of State.

F. In addition to complying with the requirements in A.R.S. § 36-1932, the bill of sale, signed by the client, shall include the following:
1. Detailed description of warranty information,
2. Year hearing aid was manufactured, and
3. Full disclosure of the conditions of any offer of a trial period with a money back guarantee or partial refund. A trial period shall not include any time that the hearing aid is in the possession of the dispenser or the manufacturer.

G. A dispenser shall notify the Director in writing of any change in business address within 30 days of the change.

Historical Note
Adopted effective June 25, 1993 (Supp. 93-2).

R9-16-312. Inspection Requirements

A. A dispenser's place of business shall have available for inspection by the Department the following:
1. Audiometer that performs the audiometric tests as outlined in R9-16-311(A);
2. Documentation which provides evidence of annual calibration of the audiometer in accordance with the American National Institute Standards, S3.6-1989, Standards Secretariat, c/o Acoustical Society of America, 335 East 45th Street, New York, New York 10017-3483, May 23, 1989, and no further amendments, incorporated herein by reference and on file with the Office of the Secretary of State;
3. Customer record for each client which shall include the following:
   a. Written statement from a licensed physician that the customer has medical clearance to use hearing aids or a medical waiver signed by the customer 18 years of age or older,
   b. Copy of the bill of sale,
   c. Audiometric test results by date performed and signed by the person performing the tests, and
   d. Contracts, agreements, warranties, trial periods, or other documents involving the client.

B. The records referenced in subsection (A) shall be retained for 36 months from date of sale.

Historical Note
Adopted effective June 25, 1993 (Supp. 93-2).

R9-16-313. Complaint Procedure

A. All complaints filed against a dispenser relating to the practice of fitting and dispensing hearing aids shall be submitted in writing to the Department. The complainant shall submit a statement of the facts and provide copies of all documentation which may support the alleged violation of state statutes or rules.

B. The Department shall send a certified letter to the dispenser describing each complaint. The dispenser shall provide to the Department, within 15 days of receipt of the certified letter, a written response addressing each allegation.

C. The Department shall review each complaint and the corresponding response by the dispenser. A certified letter shall be sent to both the complainant and the dispenser notifying them of any action to be taken by the Department.

D. A dispenser may appeal an action taken by the Department in accordance with A.A.C., Title 9, Chapter 1, Article 1, Rules of Practice and Procedures.

Historical Note
Adopted effective June 25, 1993 (Supp. 93-2).

R9-16-314. Enforcement Actions

A. In accordance with A.R.S. § 36-1934, the following factors shall be considered in determining the length of suspension or revocation, or conditions thereof, or the level of disciplinary action for any violation of A.R.S., Title 36, Chapter 17 or this Article:
1. Severity of the offense;
2. Danger to the public;
3. Number of specified offenses;
4. Degree of damage, physical or otherwise, to the consumer;
5. Number and nature of prior offenses;
6. Degree of cooperation displayed in resolving past or recent complaints and violations;
7. Degree of negligence pertaining to any violation; and
8. Other mitigating or aggravating circumstances.

B. Upon consideration of the factors outlined in subsection (A), the Director may revoke or suspend a license permanently or for a fixed period and may impose the following:
1. Suspend all or certain areas of the dispenser's practice where the dispenser has shown unethical conduct or incompetence in the conduct of the practice;
2. Restrict the practice of a dispenser to only those activities that are directly supervised by a licensed dispenser; and
3. Prescribe a period of probation in which the dispenser shall obtain a specified number of CE hours in areas where the dispenser has shown negligence, unethical behavior, or incompetence in the conduct of the practice.

Historical Note
Adopted effective June 25, 1993 (Supp. 93-2).

ARTICLE 4. REGISTRATION OF SANITARIANS

R9-16-401. Legal authority

The Sanitarians' Council, a component of the Arizona Department of Health Services, pursuant to the authority granted in A.R.S. § 36-136.01, hereby adopts the following Regulations for the registration of sanitarians.

Historical Note
Adopted effective September 29, 1976 (Supp. 76-4).

R9-16-402. Definitions

In Article 4, unless the context otherwise requires:

1. "Continuing education unit" means ten contact hours of participation in an organized continuing education experience under responsible sponsorship, capable direction and qualified instruction. One contact hour is the equivalent of 50 minutes of classroom study.
2. "Council" means the Sanitarians' Council established by the Director.
3. "Department" means the Department of Health Services.
4. "Director" means Director of the Department.
5. "Registered sanitarian" means a sanitarian registered in accordance with provisions of A.R.S. § 36-136.01.
6. "Sanitarian aide" means a person who performs specific environmental sanitation activities under the supervision of a registered sanitarian pursuant to R9-16-409(B)(6) and R9-16-409(C). A high school education or its equivalent shall be the minimum educational qualifications for the sanitarian aide.
7. "Sanitarian-in-training" means a person who:
   a. Possesses the necessary education or experience required to become eligible for registration as a sanitarian in Arizona; and
   b. Has submitted evidence that he has been accepted to work in the field of environmental health by a health department, school, government agency or by private industry; and
   c. Has filed an application with the Council for registration as a sanitarian.
8. "Training agency" means an institution, governmental agency, private business enterprise, or association which conducts a course or program of instruction which will qualify for continuing education credit pursuant to R9-16-413(E).

Historical Note
Adopted effective September 29, 1976 (Supp. 76-4).
Amended effective April 12, 1985 (Supp. 85-2).

R9-16-403. Reserved

R9-16-404. Reserved

R9-16-405. Reciprocity

A. The Council will issue a registration certificate without examination to an applicant who holds a current and valid certificate issued under laws or a voluntary certification program of any other state, territory or the District of Columbia, provided:
   1. The out-of-state certificate was issued as the result of successfully passing an examination developed by an examination service used by the Council for use by state or other governmental sanitarian registration agencies within the ten year period next preceding the date of application for current Arizona registration and,
   2. The applicant meets the requirements of A.R.S. § 36-136.01(G).

B. The Council may also issue a registration certificate without examination to an applicant who meets the requirements of A.R.S. § 36-136.01(G), if the examination which was successfully passed was substantially equivalent to the examination described in R9-16-408(B), but was taken prior to the ten year period preceding application, if proof of completion of ten contact hours of continuing education courses per year for the previous three years, is provided with the application. The continuing education courses used as the basis for registration through reciprocity must be substantially related to the field of environmental health.

Historical Note
Adopted effective September 29, 1976 (Supp. 76-4).
Amended effective April 12, 1985 (Supp. 85-2).

R9-16-406. Application for registration

A. Application forms for registration as a registered sanitarian can be obtained from the Department.

B. The application fee and the completed application forms must be received by the Department at least 30 days before the date fixed for the examination or for consideration by the Council when registration without examination is involved.

C. An affirmative vote by at least three members of the Council will be required to approve any registration.

Historical Note
Adopted effective September 29, 1976 (Supp. 76-4).

R9-16-407. Fees

A. All fees shall be made payable to the State of Arizona Sanitarians Fund.

B. A fee of $40.00 shall accompany each application for initial registration as a sanitarian by examination or reciprocity. Where examination is required, this fee is non-returnable.

C. A fee of $10.00 shall be submitted with a completed application form for the annual renewal of a registration certificate. Annual renewal fees are due and payable on December first. A published list of registered sanitarians will be issued on February 15. The names of those who have not paid the renewal fee prior to January first will be omitted from the published list. Reinstatement after a period of delinquency of 12 months or more shall be subject to the filing of a new application for registration, to the passing of a written examination, and to the payment of the $40.00 application fee.

Historical Note
Adopted effective September 29, 1976 (Supp. 76-4).

R9-16-408. Examination

A. Only persons who meet the requirements set forth in A.R.S. § 36-136.01, Subsection G. shall be eligible for admission to examination for registration as a sanitarian.

B. Examinations for registration as a sanitarian will be administered not less than twice each calendar year, at such times and places in this State as may be specified by the Council. Such examinations will be written and will include such applicable subjects pertinent to the qualifications of a registered sanitarian as the Council may prescribe. The examination papers will not disclose the name of any applicant but will be identified by a number assigned by the Department. The preparation of the examination will be the responsibility of the Council, provided that the Council may at its discretion use material prepared by recognized examination agencies.

C. A person will not be registered if he fails to meet the minimum grade requirements for examination specified by the Council. If an applicant fails to meet such minimum grade requirements in his first examination, he may be re-examined at a regularly scheduled examination upon resubmitting his application

accompanied by the prescribed fees, provided that no more than two re-examinations may be administered to any person in any four-year period.

D. The examination papers, and records pertaining thereto, will be filed with the Department and retained for at least four years.

Historical Note
Adopted effective September 29, 1976 (Supp. 76-4).

R9-16-409. Registered sanitarian; examples of duties

A. There is one class of sanitarian for registration purposes. This shall not be construed to prevent further classification by an employer of registered sanitarians for personnel administration purposes. A registered sanitarian may plan, organize, manage, implement and evaluate one or more program areas comprising the field of environmental health. Environmental program areas include, but are not limited to: food, beverage, and lodging sanitation; housing, water supply sanitation; land use; solid, liquid and hazardous waste disposal; insect, rodent and vermin control; epidemiology; accident prevention; swimming pool and public bathing facility sanitation; radiation safety; air and water quality; noise pollution; and institutional and industrial hygiene. In performing these activities, a registered sanitarian is involved in sanitation related community education, investigation, consultation, review of construction plans, collecting of samples, interpreting laboratory data, enforcement actions and development of regulations.

1. All registered sanitarians must be proficient in the following general duties:
   a. Development and execution of one or more phases, or one or more activities, of an environmental health program.
   b. Performance of responsible environmental health work in a health department, school, government agency or in private industry.
   c. Conduct of investigations of potential environmental health problems and the preparation of suitable recommendations for their solutions.
   d. Submission of reports of duties performed including evaluations and recommendations for improvement of programs.
2. A registered sanitarian may also:
   a. Prepare and present environmental health information for teaching public health concepts.
   b. Promote improvement in environmental health practice and enforcement of State laws and local ordinances through skillful presentation of facts to the public.
   c. Supervise other registered sanitarians or sanitarian aides.

B. The requirement of A.R.S. § 36-136.01 for registration do not apply to:

1. Any person teaching, lecturing or engaging in research in environmental health but only insofar as such activities are performed for academic purposes.
2. Any person who is a sanitary engineer, public health engineer, public health engineering assistant or registered professional engineer except when they are working as a sanitarian.
3. Any public health officer or public health department director pursuant to A.R.S. §§ 36-163 or 36-184.
4. Any person who holds an Arizona license to practice medicine and surgery or veterinary medicine.
5. Laboratory personnel when performing or supervising the performance of sanitation related laboratory functions.
6. Any person employed in environmental sanitation by a State or local governmental agency whose duties are restricted to inspection of one of the following:
   a. Air pollution control
   b. Barber shops
   c. Bedding
   d. Bees and honey
   e. Cosmetology shops
   f. Eggs
   g. Foster homes
   h. Grading, sampling and labeling of dairy products
   i. Grain warehouses
   j. Meat
   k. Pesticide applications
   l. Plumbing
   m. Public and semi-public bathing places
   n. Produce
   o. Septic tank installations
7. A sanitarian-in-training for a period not to exceed one year.

This exception does not apply to persons whose duties include a combination of those listed in R9-16-409(B)(6) or one of those listed in R9-16-409(B)(6) in combination with other duties related to environmental sanitation.

C. Sanitarian aides and sanitarians-in-training shall be directly supervised by a registered sanitarian in accordance with the following provisions:

1. No approval or disapproval for operation of a permitted establishment or regulated facility shall be granted.
2. All inspection reports shall be reviewed and co-signed by a registered sanitarian.
3. Permission to operate a regulated establishment shall be decided by the registered sanitarian reviewing the inspection reports.

Historical Note
Adopted effective September 29, 1976 (Supp. 76-4).
Amended effective April 12, 1985 (Supp. 85-2).

R9-16-410. Denial of application for registration

A. The Council may deny an application for registration if the applicant has:

1. Made a false statement of fact in the application; or
2. Been convicted of a crime relating to the qualifications or activities as a registered sanitarian, unless clear and convincing evidence of completion of a rehabilitative course of therapy is presented; or
3. Committed an act of fraud or negligence resulting in a revocation or denial of an application for registration, within the past three years, unless clear and convincing evidence of retraining or other appropriate rehabilitation such as community service work is presented; or
4. Omitted the required information; or
5. Failed the examination or failed to qualify for the examination; or
6. Failed to obtain continuing education as required by R9-16-405(B) or R9-16-413.

B. Upon denial of an application for registration under this rule, the Council shall notify the applicant that the application is denied, stating:

1. The reason(s) for denial; and
2. That the applicant has the right to a hearing if written request for hearing is filed with the Director within the 15 days after service of the notice of denial. Service of notice of denial shall be made by certified mail, return receipt requested, addressed to the applicant at the latest address filed by the applicant in writing with the Council.

C. The Administrative Procedures Act (A.R.S. § 41-1001 et seq.) and the Department rules of practice and procedures (R9-1-111 et seq.) will govern all hearings required by this Article.

Historical Note
Adopted effective September 29, 1976 (Supp. 76-4). Former Section R9-16-410 repealed, new Section R9-16-410 adopted effective April 12, 1985 (Supp. 85-2).

R9-16-411. Suspension and revocation of registration

A. The Council may recommend to the Director that disciplinary action be taken against the holder of a certificate or registration who commits any of the following acts:
1. Fraud or misrepresentation in obtaining a certificate, whether in the application or qualification examination;
2. Gross negligence, bribery or incompetence in the practice of the profession;
3. Aiding, abetting or knowingly conspiring with an unregistered person to evade provisions of this Article.
4. Allowing one's registration to be used by an unregistered person or acting as agent, partner, or associate of an unregistered person with intent to evade provisions of this Article.
5. Violating the rules of this Article.
6. Committing a crime related to activities as a registered sanitarian.

B. If a majority of the quorum of the Council find the holder of a certificate or registration has violated any of the provisions of R9-16-411(A), the Council may recommend to the Director, in writing, that the sanitarian be placed on probation, or the certificate be suspended or revoked.

C. The Council will notify the sanitarian of any such disciplinary recommendation by certified mail, return receipt requested, addressed to the sanitarian at the latest address filed by the sanitarian in writing with the Council.

D. If the Director decides to take disciplinary action against any sanitarian in accordance with the provisions of R9-16-411(B), there shall be a hearing conducted according to the provisions set forth in rule R9-1-101 et seq., unless waived in writing by the sanitarian.

E. Any orders for probation, suspension, or revocation imposed by the Director shall stipulate all requirements necessary to restore the sanitarian to regular status.

F. The Director shall immediately notify each county or city health department in the State of the suspension or revocation of a certificate or of the reissuance of a suspended or revoked certificate.

G. Decisions of the Director shall be subject to judicial review pursuant to A.R.S. Title 12, Chapter 7, Article 6.

Historical Note
Adopted effective September 29, 1976 (Supp. 76-4). Former Section R9-16-411 renumbered as Section R9-16-414, new Section R9-16-411 adopted effective April 12, 1985 (Supp. 85-2).

R9-16-412. Re-registration

A. A sanitarian whose registration has been suspended for a period of time shall automatically be re-registered at termination of the period of suspension if all stipulations in the order of suspension have been met. If the period of suspension extends from one calendar year into the next, then the procedure for renewal as described in R9-16-407(C) shall be followed.

B. A sanitarian who has had his or her registration revoked may apply to the Council for re-registration as a sanitarian. The application shall include substantial evidence that the sanitarian has completed a rehabilitative training course or therapy, or that the basis for revocation has been otherwise removed.

Historical Note
Adopted effective April 12, 1985 (Supp. 85-2).

R9-16-413. Continuing education

A. Each registered sanitarian must complete at least one continuing education unit per calendar year to be eligible to apply for renewal of registration as a sanitarian. A maximum of one continuing education unit may be accrued during any one calendar year for carryover use during the following calendar year.

B. The continuing education unit must meet the following minimum criteria in order for credit to be given by the Council:
1. It is a course of study directly related to the responsibilities of a sanitarian in carrying out administrative, educational, investigational or technical duties in the field of environmental health;
2. It must have a specific, written objective(s) which describes expected outcomes for the participant.
3. It must be presented by a college or university accredited by an agency approved by the Council on Post-Secondary Accreditation or by a knowledgeable person(s) who has specialized training and experience in the subject being covered in the program.
4. It must last at least one contact hour.
5. It must utilize a mechanism to validate participation. This may include, but is not limited to, earned credits or verification of attendance.
6. It incorporates course evaluation procedures for measuring the effectiveness of the program.

C. The Council may defer the continuing education requirement to allow certificate holders to practice if the applicant is able to show good cause why the continuing education requirements could not be timely met. The request for deferral must be enclosed with the application for renewal. The deferred contact hours must be completed during the year for which the license is issued. No more than one consecutive year of deferred continuing education shall be granted by the Council.

D. Certificates or other documentation of attendance or completion of continuing education activity must be submitted with each renewal application unless a deferral is requested.
1. A copy of a certificate or other documentation must have the subject or subject matter covered, the date or dates of attendance, the location of the activity, the number of contact hours completed while in attendance and signature of the registrant.
2. It is the responsibility of the registered sanitarian to assure that required evidence of compliance with the continuing education requirements is submitted to the Council on forms provided by the Council.
3. If a registered sanitarian attends a continuing education course which has not been approved by the Council, the registered sanitarian may request, at the time of registration renewal or before, that the course be approved for continuing education credit. For the Council to consider a request from a registered sanitarian to receive continuing education credit, the registered sanitarian must submit documentation to the Council which indicates that the course meets the requirements of this rule.
4. The Council shall act on all requests for renewal of registration or approval of continuing education courses received from registered sanitarians under this rule within sixty days of receipt.

E. A training agency may apply to the Council for recognition of its courses as continuing education for registered sanitarians.

Eligibility for specific continuing education units or fractions thereof will be determined by the Council in accordance with the criteria set forth in Subsection B. of this Section.

Historical Note
Adopted effective April 12, 1985 (Supp. 85-2).

R9-16-414. Violations
Any person or agency who violates any provision of this Article is subject to the penalties provided by A.R.S. § 36-140

Historical Note
Former Section R9-16-411 renumbered as Section R9-16-414 effective April 12, 1985 (Supp. 85-2).

TITLE 9. HEALTH SERVICES

CHAPTER 17. DEPARTMENT OF HEALTH SERVICES PURE FOOD CONTROL

ARTICLE 1. RESERVED

ARTICLE 2. FOOD STANDARDS

Section

R9-17-201. Enrichment of flour, cereals and related food products
R9-17-202. Fortification of flour, cereals and related food products
R9-17-203. Labeling of enriched or fortified flour, cereals and related food products

ARTICLE 3. AFLATOXIN IN ANIMAL FEED

R9-17-301. Reserved
R9-17-302. Reserved
R9-17-303. Reserved
R9-17-304. Reserved
R9-17-305. Reserved
R9-17-306. Reserved
R9-17-307. Reserved
R9-17-308. Reserved
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R9-17-311. Definitions
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R9-17-315. Approved laboratories
R9-17-316. Sampling
R9-17-317. Method of analyzing whole cottonseed
R9-17-318. Methods of ammoniation
R9-17-319. Labeling requirements
R9-17-320. Record requirements
R9-17-321. Enforcement action

ARTICLE 1. RESERVED

ARTICLE 2. FOOD STANDARDS

R9-17-201. Enrichment of flour, cereals and related food products

A. Definitions and standards of identity for cereal flours and related products (21 CFR Part 15), macaroni and noodle products (21 CFR Part 16), and bakery products (21 CFR Part 17) and any amendments to such definitions and standards adopted pursuant to the federal Food, Drug and Cosmetic Act, as amended (21 USC 301 et seq.), which are in effect on the effective date of this regulation are the definitions and standards of identity for all such products in this state. When a definition and standard of identity for an enriched form of such product has been established and adopted pursuant to the federal act, only the enriched form of such product shall be sold in Arizona.

B. The sale in Arizona of any product subject to subsection (A) of this regulation which conforms to definitions and standards which are adopted pursuant to the federal act subsequent to the effective date of this regulation shall be deemed to be in compliance with subsection (A).

R9-17-202. Fortification of flour, cereals and related food products

It is the intention of the Board to adopt standards of identity governing the quantity of vitamins and minerals to be added to, or a level of nutritional quality to be achieved in, processed cereals at such time as such standards are adopted pursuant to the federal act.

R9-17-203. Labeling of enriched or fortified flour, cereals and related food products

A. Label statements and labeling requirements for cereal flours and related products, macaroni and noodle products, bakery products and processed cereals, and any amendments thereto adopted pursuant to the federal Food, Drug and Cosmetic Act, as amended (32 U.S.C. 301, et seq.) which are in effect on the effective date of this regulation are the label statements and labeling requirements for this state. No such product shall be sold in Arizona unless such product meets these labeling and label statement requirements.

B. The sale in Arizona of any product subject to subsection (A) of this regulation which conforms to labeling and label statement requirements which are adopted pursuant to the federal act subsequent to the effective date of this regulation shall be deemed to be in compliance with subsection (A).

ARTICLE 3. AFLATOXIN IN ANIMAL FEED

R9-17-301. Reserved

R9-17-302. Reserved

R9-17-303. Reserved

R9-17-304. Reserved

R9-17-305. Reserved

R9-17-306. Reserved

R9-17-307. Reserved

R9-17-308. Reserved

R9-17-309. Reserved

R9-17-310. Reserved

R9-17-311. Definitions

In this Article, unless the context otherwise requires:

1. "Aflatoxin" means the sum of concentrations of all specific aflatoxins identified in the testing conducted pursuant to this Article.
2. "Approved laboratory" means an analytical facility which examines ammoniated cottonseed for aflatoxin and has been issued a certificate under this Article.
3. "Cottonseed distributor" means any person holding a commercial feed license issued by the State Chemist pursuant to A.R.S. § 24-911 who distributes cottonseed or any person who distributes cottonseed for feed purposes.
4. "Dairy animals" means all animals whose milk is intended for human consumption.
5. "Department" means Arizona Department of Health Services.
6. "Director" means the Director of the Department of Health Services.
7. "Lot" means any distinct, describable and measurable configuration of cottonseed which contains no more than one hundred tons. For purposes of calculating lot size, one cubic foot of whole cottonseed equals twenty-six pounds.
8. "Non-dairy animals" means all animals, other than dairy animals as defined in paragraph (4), above, including

without limitation, those animals whose milk is not intended for human consumption.

Historical Note
Adopted effective May 13, 1981 (Supp. 81-3).

R9-17-312. Legal authority
The regulations in this Article, are adopted pursuant to the authority granted by A.R.S. §§ 36-132, 36-136, 36-473, 36-904.01, 36-905 and 36-911.

Historical Note
Adopted effective May 13, 1981 (Supp. 81-3).

R9-17-313. Enforcement levels
A. Cottonseed containing aflatoxin in excess of 20 parts per billion is not permitted for use in rations of dairy animals.
B. Cottonseed containing aflatoxin in excess of 100 parts per billion is not permitted for use in the rations of non-dairy animals.
C. The sampling and testing methods specified in R9-17-316 and R9-17-317 shall be followed for purposes of compliance with the testing, sampling and analysis requirements of A.R.S. § 36-904.01 and R9-17-314 through R9-17-317.

Historical Note
Adopted effective May 13, 1981 (Supp. 81-3).

R9-17-314. Scope
A. An analysis shall be performed on samples of cottonseed drawn according to the sampling and testing methods referenced in this Article. The analysis will remain valid for the lot or an identifiable portion of the lot. However if the lot, or a portion thereof, is mixed with another ingredient or comingled with a material of similar composition, except for purpose of making up daily mixed fee rations, a new analysis shall be required. All cottonseed which has not previously been tested shall be evaluated for aflatoxin content prior to its final use as a feed or feed ingredient.
B. No sale, transfer, distribution, mixing, processing or feeding of any lot of ammoniated whole cottonseed or ammoniated cottonseed product shall be conducted prior to completion of a written report by a laboratory certified pursuant to R9-17-315 showing the aflatoxin content of such lot of cottonseed, based on analysis performed pursuant to R9-17-317.
C. No lot of ammoniated whole cottonseed or ammoniated cottonseed product shall be used as animal feed unless the written results of an analysis performed pursuant to R9-17-315 through R9-17-317 indicate that the aflatoxin content of such lot has been reduced to acceptable levels for those animals to which it is intended to be fed and the labeling so states.

Historical Note
Adopted effective May 13, 1981 (Supp. 81-3).

R9-17-315. Approved laboratories
A. Application for certification.
1. A laboratory which desires to perform testing required by A.R.S. § 36-904.01 and has not been certified by A.R.S. § 145 shall first apply to be certified by the Director as a laboratory which meets the standards to perform aflatoxin testing of ammoniated cottonseed stated in this Article. Any laboratory found by the Director to comply with the standards required by this Article will be certified as an approved laboratory. To obtain this certification, the laboratory must apply to the Department for a certificate on a form provided by the Department. The application shall be prepared and signed by both the owner of the laboratory and the laboratory director.

B. Revocation of certification.
1. The Director may revoke the certificate of an approved laboratory if it fails to comply with the provisions of this Article as determined by an on-site evaluation by a representative of the Department.

C. Quality assurance program.
1. Each laboratory shall provide a complete written manual, readily available to all personnel, for procedures, required to be performed in the laboratory by this Article. This shall be reviewed periodically by the laboratory director who also approves any changes, additions, deletions, etc. The manual shall include, but not be limited to, the following:
   a. Specific instructions for the proper collection and handling of samples, if pertinent, shall be available to both laboratory personnel and people outside the laboratory who may be responsible for collecting samples. These instructions shall follow established protocols and include the number of units to be sampled, the locations from which obtained and the quantity of material to be submitted, Criteria shall be established for accepting samples and instructions delineated for storage in the laboratory.
   b. Safety precautions unique to specific procedures shall be outlined. These must meet standards required by Chapter 14, Article 1 of this Title.
   c. Specific written methodology protocols shall include, but not be limited to, the following:
      i. Instrumentation, glassware and equipment.
      ii. Detailed instructions for performing the test.
      iii. Equipment calibrations and testing conditions.
      iv. Criteria for recording standards, controls and test results.
      v. Criteria for repeating the test.
      vi. Maximum allowable contaminant levels.
      vii. Instructions for performing calculations.
      viii. References.
   d. There shall also be available a complete description of the facility's quality assurance program defining policies, including, but not limited to, the following:
      i. Recovery data for control cottonseed.
      ii. Confirmation of results by official method.
      iii. Storage and handling of standards.
   e. If test results may be used in evidence before a court or government agency, a written chain of evidence protocol shall be established.
2. A maintenance schedule shall be established for those equipment functions which must be performed periodically. Records shall be kept of these checks and also of any repair and non-scheduled service. The maintenance and calibration schedules shall include the following:
   a. Standard procedures for the set-up and normal operation of each instrument and, if pertinent, the specific instructions for checking periodically the reproducibility of the system.
   b. Instructions for regular checking and recording of the critical operating characteristics of all instruments.
   c. Functional check documentation in a convenient record including acceptable tolerance limits.
   d. Records of monitoring of temperature controlled spaces.

e. Certification that thermometers and analytical balance weights meet National Bureau of Standards criteria.
f. Systems for evaluation of glassware and volumetric equipment.

D. Laboratory test results.
1. Laboratory records shall include the following information for each specimen:
a. Identification of sample.
b. Tests requested.
c. Description of sample and collection process.
d. Sample preparation.
e. Method of analysis.
f. Analytical data recorded as obtained.
g. Calculations.
h. Dates of collection, receipt and report.
2. Records of observations bearing on the final results and test results shall be recorded concurrently with the performance of each step in the examination of the sample and recorded concurrently with the performance of each calibration and control procedure.
3. Standardization, calibration and control records shall be maintained in such a manner so as to provide correlation of this data with sample results. Standardization, calibration and control limits shall be established, recorded, and notation of "out-of-control" results made with the appropriate remedial action and corrected results.

E. Sanitation and safety.
1. All laboratories shall be maintained and operated to prevent undue physical, chemical, and biological hazards to its employees or other members of the community. To ensure this, the following shall be met:
a. Physical facilities and utilities shall be capable of supporting all types of procedures done and for the specific workload of the laboratory section.
b. Flammable liquids shall be stored in compliance with National Fire Protection Association Codes. Storage areas and rooms where volatile solvents are stored shall be adequately ventilated and safety cans shall only be used for appropriate volumes of volatile liquids. One quart or less of flammables in current use may be stored in open shelves.
c. Complete instructions for disposal of contaminated material shall be available. Laboratories are responsible for establishing and observing policies for all real or potential hazards of laboratory wastes.
d. Policy manuals shall define specific fire and safety procedures for the laboratory including the proper handling of suspected hazardous sample materials. These regulations shall be written and posted or readily available to personnel.
e. An annual fire inspection shall be required.
f. Fire extinguishers shall be present in laboratory sections performing tests required by this Article.
g. There shall be an inventory of all materials which are labeled as hazardous or carcinogenic.
h. Compressed gases shall be properly secured by means of chains, base stands sufficiently strong to support weight of cylinder, or brackets. Acetylene or other extremely hazardous gases shall be stored outside the facility and piped in, or stored in accordance with National Fire Protection Association, Code 56-c.
i. There shall be an emergency water supply such as showers, hoses, eyewashes, or flushing devices convenient to areas where caustic materials are used, reagents prepared, acid cleaning of glassware, or other high risk areas.

F. Proficiency testing.
1. Each laboratory shall participate in an approved Aflatoxin Check Sample program and shall be required to submit to the Department a copy of its test results.
2. If deficiency is noted during on on-site evaluation or in the examination of split-samples, the laboratory shall submit to the Department a plan of corrective action designed to eliminate the deficiency.

Historical Note
Adopted effective May 13, 1981 (Supp. 81-3).

R9-17-316. Sampling

A. Sample size and identification.
1. Not less than one separate gross sample of not less than thirty pounds shall be taken from each lot. Each gross sample shall consist of not less than ten probes (3 lbs. of sample each) or ten stream sample passes (3 lbs. each) taken following the procedure outlined in subsection (D) of this Section.
2. Although only one sample per lot is required, two additional samples for research purposes may be collected and sent to the University of Arizona Cotton Research Center, 4201 East Broadway, Phoenix, Arizona 85040.

B. Sample container.
1. A sample container for non-ammoniated whole cottonseed shall consist of a cloth, burlap or paper bags. The sample container for ammoniated whole cottonseed may be plastic bags if the sample is kept below 605F. If this temperature cannot be maintained, the container shall be burlap or cloth bags, and stored in a dry, well aeriated location. The sample shall be delivered to the laboratory within twenty-four hours. Samples collected for research shall be delivered to the research center within twenty-four hours. All bags shall be clean and new and shall not be reused.

C. Sampling equipment.
1. The following sampling equipment shall be utilized:
a. Scale, graduated in 1/2 lb. increments to at least thirty-one lbs.
b. Trier or corkscrew, made of strip steel 1/2 inch wide by 5/32 inch thick, bent to form an open cylinder 3 inches in diameter, the pitch of the twist being approximately 2 inches and the screw portion being approximately 56 inches or greater in length.
c. Pneumatic probe sampler. A pneumatic probe sampler which, by way of example includes, but is not limited to, the Probe-A-Vac Pneumatic Grain Sampler.
d. Stream sampler - a container approximately 8 x 5 x 5 1/2 inches attached to a pole long enough to enable the sampler to pass the bucket through falling stream of cottonseed.

D. Sampling procedure.
1. All probe samples shall be taken according to the following patters:
Eight of the ten probe samples shall penetrate to a minimum depth of fifty-six inches, or one-half the diameter of the pile or the bottom of the load. Not less than two of ten probe samples must reach the center (1/2 the diameter) of a pile or the bottom of the lot being sampled. These two probes shall be taken from:
a. For Figures 1 and 2 above, from points 4 and 6 or 3 and 5.
b. For Figure 3 above, from points 1 and 5 or 2 and 3.

c. For Figure 4 above, from points 2 and 7 or 4 and 9. The probe shall be inserted at an angle perpendicular to the face of the lot. A pneumatic probe shall be inserted with an easy up and down motion to prevent clogging.

2. Stream samples may be taken while the material is being discharged, if there is a uniform discharge flow over a set period of time. Sampler shall take not less than ten evenly timed and spaced passes through discharge flow, resulting in the proper sample size.
3. After the full gross sample is drawn, the entire sample shall be weighed to the nearest one-half pound. In no case shall the gross sample be reduced in size. If any gross sample does not meet the minimum thirty pound weight, that gross sample shall be discarded and the procedure repeated from the beginning.
4. Truck load lots of cottonseed shall be sampled by taking at least ten probes at uniformly separated locations throughout the load as shown in Figure 1 of this Section.

Historical Note

Adopted effective May 13, 1981 (Supp. 81-3).

R9-17-317. Method of analyzing whole cottonseed

A. Sample preparation.
1. High moisture ammoniated or other wet samples shall be dried within twenty-four hours of receipt by the laboratory at a temperature not less than 30° C. and not more than 130° C. until they have dried sufficiently to be dehulled. If the sample cannot be dried within twenty-four hours, it shall be maintained at 16° C. or less until it can be dried.
2. The entire sample shall be weighed after drying. This weight and the weight from R9-17-316.D. will be used in Method of reporting (see subsection (C), paragraph (2) of this Section).
3. The entire sample shall be dehulled by passing it though a mill or decorticator to crack at least 99% of hulls.
4. Meats shall be separated from hulls by sieve, shaker, scalper or beater.
5. After separation of hulls and meats, each fraction shall be weighed for use in determining weights in Method of reporting (see subsection (C), paragraph (1) of this Section).
6. The entire sample of meats shall be ground to pass a 20 mesh screen.
7. The ground meats shall be blended in a double cone or twin shell blender or small cement type mixer for a minimum of fifteen minutes.
8. The laboratory sample of approximately 1100 grams shall be drawn by passing ground meats through a divider system such as a Boerner or riffle.
9. An analytical sample of approximately 250 grams shall be drawn by dividing the laboratory sample with a riffler.
10. The retained portion (approximately 850 grams) of the sample shall be refrigerated at a temperature of 16° C. or less.
11. High moisture is defined as 10% moisture by weight.

B. Sample analysis.
1. Thin layer chromatography.
   a. Determination of aflatoxin in cottonseed shall be performed according to Official Methods of Analysis of the Association of Official Analytical Chemists, Section 26.052-26.060 (13th Edition, 1980).
   b. Confirmation procedures shall be done according to Official Methods of Analysis of the Association of Official Analytical Chemists, Sections 26-076, 26.082 or 26.083 (13th Edition, 1980).
   c. The following modifications shall be permitted to the above method:
      i. Precipitation of the extract using 2.5 ml of a solution of 20% aluminum chloride and 15 ml of a 20% solution of zinc acetate.
      ii. Liquid partitioning of the aflatoxin into chloroform.
      iii. The use of a tank solvent of formic acid, ethyl acetate and toluene (1 + 3 + 6).
2. Liquid chromatography.
   a. High performance liquid chromatography may be used as an alternate to thin layer chromatography (see Official Methods of Analysis of the Association of Official Analytical Chemists, Section 26-A09, 13th Edition, 1st Supplement, 1980).
   b. The use of a fluorometric detector with a silica gel-packed flowcell may be used if it complies with the description in the Journal of the Association of Official Analytical Chemists, Vol. 60 No. 3, 1977 by Thavil, Panalaks and Scott, entitled "Sensitive Silica Gel-Pack Flowcell for Fluorometric Detection of Aflatoxins by High Pressure Liquid Chroma- tography". A copy of the Journal of the Association of Official Analytical Chemists procedure is on file with the Secretary of State.
   c. The following modifications are permitted to the above method:
      i. Precipitation of the extract using 2.5 ml of a solution of 20% aluminum chloride and 15 ml of a 20% solution of zinc acetate.
      ii. Liquid partitioning of the aflatoxin into chloroform.

C. Method of reporting.
1. The following formula shall be used to calculate the amount of aflatoxin in the dried whole seed:
   a. Weight of meats divided by the sum of the weight of hulls plus weight of meats times the ppb of aflatoxins b_1 and b_2 found which is equal to the pbb of aflatoxin in dried whole seed.
2. The results of the aflatoxin tests shall be reported on an "as taken" basis and the following formula shall be used:
   a. Weight of the dried seed (as described in subsection (A), paragraph (1) of this Section) divided by the weight of seed when taken (as described in R9-17-316(D)(3)) times the ppb aflatoxin in dried whole seed (calculated in subsection (C), paragraph (1) of this Section) which is equal to the ppb aflatoxin "as taken".
3. Determination of pass-fail samples.
   a. An initial single sample shall be run and if the results are 20 ppb or less for dairy animals, or 100 ppb or less for non-dairy animals it shall be considered as a passed sample.
   b. If the results of a single sample are greater than 20 ppb or 100 ppb, on a 20 ppb or 100 ppb level respectively, the sample shall be rerun in duplicate.
   c. If the average of all three tests of a sample run for a 20 ppb level, is over 20 ppb, it shall be described as a failed sample. If the average of all three tests of a sample run for a 100 ppb level, is over 100 ppb, it shall be described as a failed sample.

Historical Note

Adopted effective May 13, 1981 (Supp. 81-3).

R9-17-318. Methods of ammoniation

The Otis Lough Process for Aflatoxin Reduction (OLPAR) method is authorized by the Director for treatment of cottonseed. Any other method must be approved by the Director to be safe and effective prior to its use. Any person may apply to the Director for approval of an alternate method of ammoniation. The Director shall establish an advisory committee to make recommendations about the safety and effectiveness of ammoniation processes other than the Otis Lough Process for Aflatoxin Reduction method. The committee shall be comprised of a public health official designated by the Director, the Dairy Commissioner or his designee, the State Chemist or his designee, a member of the College of Agriculture of the University of Arizona, one person nominated by the Commission of Agriculture and Horticulture, and one representative each from the feed, cattle, cotton, and dairy industries. The Director will approve or disapprove any proposed alternate method based on his determination of its safety and effectiveness. A copy of the Otis Lough Process for Aflatoxin Reduction is on file with the Secretary of State.

Historical Note

Adopted effective May 13, 1981 (Supp. 81-3).

R9-17-319. Labeling requirements

Prior to its final use as a feed or feed ingredient, all whole cottonseed, except cottonseed that has been ammoniated on the premises of a dairy or feed lot and is not intended for further distribution, shall be accompanied by an invoice which clearly states, as applicable:

1. This cottonseed contains not more than 20 parts per billion (ppb) or aflatoxin and may be fed to any animal; or
2. For distribution and use only in Arizona -- non-dairy animal feed. This cottonseed contains not more than 100 parts per billion (ppb) of aflatoxin and may be fed to any animals except those whose milk is intended for human consumption; or
3. This cottonseed contains more than 100 parts per billion (ppb) aflatoxin and may not be fed to any animals.

Historical Note

Adopted effective May 13, 1981 (Supp. 81-3).

R9-17-320. Record requirements

A. Any cottonseed distributor who is required to test for aflatoxin under these regulations shall keep records to be made available to the Department and the State Chemist for a period of three years which shall contain the following information:

1. Name or description of product.
2. Identity of lot sampled and analytical results reported for aflatoxin content.
3. Weight of product.
4. Name, mailing address and location of person to whom the product was distributed.
5. Name and address of person invoiced.
6. Date of distribution.

B. Any person ammoniating cottonseed shall file with the Department a copy of the written results of the aflatoxin content as determined by an approved or certified laboratory prior to any sale, transfer, distribution, mixing, processing, or feeding of the ammoniated cottonseed.

Historical Note

Adopted effective May 13, 1981 (Supp. 81-3).

R9-17-321. Enforcement action

A. Any cottonseed or cottonseed product which is not intended for ammoniation or has been ammoniated and exceeds the enforcement levels established in R9-17-313 of this Article shall be deemed adulterated and may be removed from distribution by embargo.

B. Any cottonseed or cottonseed product deemed to be adulterated with aflatoxin by the Department or the State Chemist shall not be blended with any other feed or feed ingredient. Any cottonseed or cottonseed product containing aflatoxin above 20 parts per billion shall not be blended with any other feed or feed ingredient to provide feed for dairy animals. Any cottonseed or cottonseed product containing aflatoxin above 100 parts per billion shall not be blended with any other feed or feed ingredient to provide feed for any animal.

Historical Note

Adopted effective May 13, 1981 (Supp. 81-3).

TITLE 9. HEALTH SERVICES

CHAPTER 18. DEPARTMENT OF HEALTH SERVICES
LOCAL HEALTH DEPARTMENT SERVICES

ARTICLE 1. PER CAPITA MATCHING FUNDS

Section
R9-18-101. Definitions
R9-18-102. Grant application
R9-18-103. Review and approval of application
R9-18-104. Minimum standard of personnel; waiver
R9-18-105. Required records and accounts
R9-18-106. Visitation, inspection and audit
R9-18-107. Notice to department

ARTICLE 1. PER CAPITA MATCHING FUNDS

R9-18-101. Definitions

The following definitions shall apply in this Article unless the context otherwise requires:

1. "Department" means the Arizona Department of Health Services.
2. "Local health department", also referred to herein as "applicant", means any established county or municipal health department in the state of Arizona.
3. "Local health department services" means programs which are funded by the Per Capita Matching Grant and which promote and protect the health of the residents in a designated service area providing services relating to communicable disease control, maternal and child health, health education, and environmental health.
4. "Objectives" means the specific results to be achieved by the local health department over a period corresponding to the state fiscal year which contain specific criteria to measure the planned and expected results.
5. "Office" means the Office of Local Health Services within the Arizona Department of Health Services.
6. "Per capita matching grant" means an allocation to a local health department, based on service population and minimum standards of personnel and performance, for local health department services which are to be matched by each local health department as provided in A.R.S. § 36-189.
7. "State fiscal year" means the period from July 1 of one year through June 30 of the following year.

Historical Note

Adopted effective April 22, 1988 (Supp. 88-2).

R9-18-102. Grant application

A. No local health department may receive a Per Capita Matching Grant from the Department for the provision of local health department services without the submission and approval of a written application which includes a plan and budget.

B. To receive such grant, an application shall be filed with the Office on forms prescribed by and available at no charge from the Office which shall include the following categories of information for each applicant:

1. Names, titles, addresses and office telephone numbers for current director or head of the local health department, its supervising body and any chief fiscal officer.
2. A current organization chart which identifies each department unit and its relationship to the whole organization, and the name and title of the person in charge of each unit.
3. A list of personnel to be directly involved in the provision of local health department services by job classification and grade.
4. A signed letter of assurance certifying that, if a grant is awarded, the applicant agrees to:
   a. Provide designated local health department services without regard to race, religion, sex, age, or handicap;
   b. Utilize a federally approved merit system according to Standards contained in 5 CFR Part 900, Subpart F, as amended as of January 1, 1987, incorporated by reference herein and on file in the Office of the Secretary of State.
   c. Comply with confidentiality of records requirements found at A.A.C. R9-1-311 through R9-1-315.
   d. Comply with report and record keeping requirements found at A.A.C. R9-18-105;
   e. Comply with matching ratio provisions of A.R.S. § 36-189;
   f. Comply with visitation, inspection and audit requirements found at A.A.C. R9-18-106;
   g. Promote and coordinate the use of local health department services; and
   h. Give recognition to the Department for its support when publishing material or releasing service-related information.
5. A narrative plan for a period corresponding to the state fiscal year which specifically identifies the purpose of each local health department service to be provided using:
   a. A needs assessment;
   b. Service objectives;
   c. Designated geographic area to be served;
   d. Ability and experience of the applicant to perform such services;
   e. Projected number of clients to be served and basis for the projection of each service as well as the number of clients previously served within the last state fiscal year;
   f. Evaluation methodology; and
   g. The specific legal authority of the applicant to provide the service for which funds are being requested.
6. The budget for the period corresponding to the state fiscal year, categorized by program if such data is available, as approved by the applicant's supervising body which clearly identifies:
   a. Treating separately the proportionate shares of the Department and the applicant and providing a total cost for each of the following:
      i. Personal services and employee-related expenditures;
      ii. Professional and outside services;
      iii. Travel expenses;
      iv. Occupancy expenses;
      v. Other operating expenses; and
      vi. Capital outlay.
   b. With regard to the source of participating funds for the applicant's share, identify:
      i. The amount of the applicant's own funds;
      ii. Amount of grants for non-department funds;
      iii. Amount of participation by other agencies and organizations; and
      iv. Amount of any other sources.

7. A comparison of actual expenditures made by the local health department during the period corresponding to the previous state fiscal year for local health department services with the amount budgeted for such services.

C. To be considered for approval, a complete application shall be filed with the Office by no later than January 1 of the current fiscal year. Failure to file a complete application by that date shall result in its denial. Such denial is final.

D. Applications shall furnish any other information as may be requested by the Office to clarify incomplete or ambiguous information contained in the application or any documents filed with the application.

Historical Note
Adopted effective April 22, 1988 (Supp. 88-2).

R9-18-103. Review and approval of application

A. Within 15 calendar days of the filing, the Office shall review and either approve or deny the application in writing, using the criteria established in R9-18-102 and A.R.S. § 36-189(A).

B. For purposes of clarification, an applicant may be required to make an oral presentation regarding its submission to the Office.

C. If the application is approved, the Office shall notify the local health department and authorize payment of the Per Capita Matching Grant within 30 days.

D. If the application is incomplete or denied for reasons other than timeliness, the notice shall clearly identify the deficiencies and give the local health department an opportunity to meet with the Office to take any and all corrective action. However, if both the meeting and corrective action do not occur within 45 calendar days after issuance of the denial notice, the denial is final and the local health department shall not be eligible to file another application until the following state fiscal year.

Historical Note
Adopted effective April 22, 1988 (Supp. 88-2).

R9-18-104. Minimum standard of personnel; waiver

A. Any registered nurse to be directly involved in community health services provided by a local health department shall have a baccalaureate degree in the science of nursing from an institution accredited by the National League of Nursing. An applicant may apply to the Office for a waiver of this requirement. Such a waiver may be granted if the applicant establishes that:
1. The registered nurse is licensed in Arizona;
2. The application of the requirement would impose an undue burden upon the applicant or the services to be provided; and
3. Granting a waiver shall not adversely affect the public health, safety or welfare.

B. Any nurse to be directly involved in clinic services provided by a local health department shall meet the definitions found in A.R.S. § 32-1601(6) or (7).

C. Any registered nurse or sanitarian providing local health department services within the state of Arizona on the date this Article is filed with the Secretary of State shall be permitted to continue to do so.

D. Any sanitarian to be directly involved in the provision of local health department services shall be currently registered in the state of Arizona.

Historical Note
Adopted effective April 22, 1988 (Supp. 88-2).

R9-18-105. Required records and accounts

A. The local health department shall maintain for review, inspection and audit the following records, reports and accounts relating to the provision of local health department services:
1. Financial records;
2. Personnel records;
3. Service and client records; and
4. Records relating to funding sources.

B. Records shall be maintained or stored for three years unless audited prior to that date. If audited, the records shall be retained until any dispute is resolved. All records, data or other documents shall be made available to the Department upon request during normal business hours.

C. Each applicant shall make a reasonable effort to protect required records from fire, flood and other hazards and safeguard the records from unnecessary deterioration. If any required record, book or other data is destroyed or lost before the prescribed retention period has elapsed, an affidavit shall be prepared and filed with the Department by the applicant listing as accurately as possible the records involved and describing the circumstances under which they were destroyed or lost.

D. Each local health department shall establish and maintain a uniform system and classification of accounts. Generally acceptable accounting principles and procedures shall be used in measuring, recording and reporting the financial affairs and activities of the applicant.

Historical Note
Adopted effective April 22, 1988 (Supp. 88-2).

R9-18-106. Visitation, inspection and audit

A. The Department may at any time inquire into the operations of the applicant with respect to the services provided and may conduct or cause to be conducted an on-site inspection in all matters affecting such services during normal business hours.

B. The funds disbursed pursuant to these rules shall be subject to audit. A refund shall be requested by the Department for any funds expended for purposes not set forth in the approved application.

Historical Note
Adopted effective April 22, 1988 (Supp. 88-2).

R9-18-107. Notice to department

The applicant shall provide written notice to the Office within 15 calendar days of any change of licensed personnel involved in the local health department services and of any material change in any circumstance upon which funds were granted.

Historical Note
Adopted effective April 22, 1988 (Supp. 88-2).

TITLE 9. HEALTH SERVICES

CHAPTER 19. DEPARTMENT OF HEALTH SERVICES VITAL RECORDS AND STATISTICS

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ARTICLE 1. ADMINISTRATIVE ORGANIZATION, DUTIES AND PROCEDURES

R9-19-101. Definitions

In this Chapter, unless the context otherwise requires:

1. "Abortional act" means a procedure or procedures by which an induced termination of pregnancy is performed.
2. "Coffin or casket" means a strong, tight, encasement composed of either natural or synthetic materials designed specifically for the interment of a body and which will ensure against menaces to the public health.
3. "Cremation" means the complete reduction of a dead human body by means of heat or fire.
4. "Delayed birth registration" means the registration of a birth on or after the registrant's 1st birthday.
5. "Delayed death registration" means the registration of a death or fetal death 1 year or more following the date of death.
6. "Department" means the Department of Health Services.
7. "Embalm" means the disinfection and preservation of a dead human body.
8. "Form" means any certificate, application, or other official document issued by the State Registrar.
9. "Independent factual document" means a record, paper, or writing which is not an affidavit and which:
   a. Memorializes a transaction, billing, legal relationship, or occurrence;
   b. Evidences the facts sought to be established by or for a registrant; and
   c. Was prepared, created, printed, or authored by a person, company, corporation, or business that is neither the registrant nor related to the registrant.
10. "Interment" means burial of the remains of a deceased individual:
    a. In an earthen grave of sufficient depth to protect against exposure of the deceased; or
    b. In a crypt or vault of a mausoleum or other durable, fireproof structure which is used for permanent disposition of dead human bodies.
11. "Late birth registration" means the registration of a birth after the 7-day period prescribed by law but before the registrant's 1st birthday.
12. "Late death registration" means the registration of a death or fetal death after the 3-day period prescribed by law but less than 1 year following the date of death.
13. "Legitimation" means the declaration of paternity of a child together with the legal marriage of the natural parents.
14. "Person acting as a funeral director" means a person other than a licensed funeral director who has assumed the responsibility for the disposition of a dead human body.
15. "Registrant" means the person named on the certificate whom the recorded event primarily concerns.

Historical Note

Former Section R9-19-101 repealed, new Section R9-19-101 renumbered from R9-19-102 and amended effective July 31, 1989 (Supp. 89-3). Amended effective February 12, 1996 (Supp. 96-1).

R9-19-102. Establishment of registration districts

A. Each county may be a registration district. Each county having a population of less than 200,000 may, in whole or in part, be a Class B registration district.

B. Geographical or political subdivisions of a county may be Class B registration districts, as needed, to ensure a complete and efficient registration system.

Historical Note

Amended effective February 20, 1980 (Supp. 80-1). Former Section R9-19-102 renumbered to R9-19-101, new Section R9-19-102 renumbered from R9-19-106 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-103 Authority of local registrars

A. The local registrar of a Class A registration district or a Class B registration district which encompasses a complete county shall have authority throughout the county and shall have the title of county registrar. In all other cases, local registrars of Class B registration districts shall have authority only within their duly assigned districts.

B. In Class B registration districts where there is no county registrar, the State Registrar shall assume the functions of the county registrar until such time as a county registrar is appointed.

Historical Note

Amended effective February 20, 1980 (Supp. 80-1). Former Section R9-19-103 repealed, new Section R9-19-103 renumbered from R9-19-107 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-104. Duties of local registrars

In addition to the duties outlined in A.R.S. § 36-308, each local registrar shall:

1. Promptly register every properly completed certificate received;
2. Be available for registration duties during normal working hours. When a local registrar is to be absent during any normal working day, the local registrar shall designate a deputy local registrar who shall assume all the duties and responsibilities of the office. In the event the absence or incapacity of the local registrar extends beyond ten days, the State Registrar shall be notified of such designation;

3. Make reasonable arrangements to enable funeral directors to obtain disposal-transit permits during non-working hours;
4. Keep timely and accurate records pertaining to registration duties; and
5. Report all deaths to the medical examiner as required pursuant to R9-19-112.

Historical Note
Amended effective February 20, 1980 (Supp. 80-1). Former Section R9-19-104 repealed, new Section R9-19-104 renumbered from R9-19-109 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-105. Removal of local registrars
The State Registrar may remove a local registrar, pursuant to A.R.S. § 36-307(B), or for any of the following causes:
1. Failure to comply with the duties and responsibilities as set forth in Chapter 3, Title 36, Arizona Revised Statutes and this Chapter;
2. Misuse of funds received pursuant to Chapter 3, Title 36, Arizona Revised Statutes or this Chapter; or
3. Permitting access to or releasing information from any certificate except as authorized by law or this Chapter.

Historical Note
Amended effective February 20, 1980 (Supp. 80-1). Former Section R9-19-105 repealed, new Section R9-19-105 renumbered from R9-19-111 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-106. Vital record forms
A. Only such forms as are prepared, printed and supplied by the State Registrar shall be used in registering, recording, amending and preserving vital statistics records and reports required by law.
B. All forms used in recording vital events shall remain the property of the state and shall be used for official purposes only. They shall be surrendered to the State Registrar upon demand and shall not be used for private or internal administrative purposes by those individuals or agencies to whom they are distributed.

Historical Note
Former Section R9-19-106 renumbered to R9-19-102, new Section R9-19-106 renumbered from Section R9-19-113 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-107. Completion standards for preparation of forms
Each form shall be legibly and neatly prepared on a typewriter with black ribbon. If no typewriter is available, the form shall be neatly printed by hand using a black, nonfading ink. All required signatures shall be in the person's own handwriting in black, nonfading ink. Signatures by rubber stamp or facsimile are not acceptable.

Historical Note
Former Section R9-19-107 renumbered to R9-19-103, new Section R9-19-107 renumbered from R9-19-114 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-108. Unacceptable forms
A form shall not be accepted for registration or other purposes if it:
1. Omits necessary information for which no satisfactory explanation and supporting documentation is provided;
2. Contains erasures, strikeovers, misplaced or illegible entries or its general appearance is soiled and untidy;
3. Is a carbon copy or is marked "copy", "duplicate" or similar notation;
4. Contains incorrect or inconsistent information;
5. Contains information which the registrar reasonable believes to be fraudulent or false; or
6. Is not completed using the form currently issued by the State Registrar; or
7. Is not completed in accordance with instructions issued by the State Registrar.

Historical Note
Former Section R9-19-108 repealed, new Section R9-19-108 renumbered from R9-19-115 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-109. Review and transmittal procedures for forms
Each local registrar shall:
1. Examine each form submitted for completeness and general appearance. If the form is not acceptable, it shall be rejected and the reasons for rejection shall be listed.
2. Maintain lists of all births, deaths and fetal deaths on registers designated for that purpose. The registers shall show the name of the registrant, date and place of the event, date of registration by the local registrar and the registrar's file number. The registers shall be available, upon request, for inspection by the State Registrar or an authorized designee.
3. Promptly transmit each form to the State Registrar, who shall consider completeness, timeliness and general appearance of each certificate in determining eligibility for payment.
   a. Class A registration districts shall retain original forms for no more than 30 days from the date of registration before forwarding them to the State Registrar.
   b. Local registrars in Class B registration districts shall forward forms to the State Registrar promptly upon receipt or at least once each week.
   c. Individual forms shall be promptly forwarded upon request of the State Registrar.

Historical Note
Amended effective March 30, 1976 (Supp. 76-2). Former Section R9-19-109 renumbered to R9-19-104, new Section R9-19-109 renumbered from R9-19-116 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-110. Assignment of state file number
A. Each birth, death and fetal death certificate shall be considered provisional until a state file number is assigned to the certificate. The assignment of a state file number indicates official acceptance of a certificate and shall precede its incorporation into the permanent files of the Department.
B. Only that copy of a birth, death or fetal death certificate, including a late or delayed registration or an authorized supplementary certificate, which is completed in accordance with these rules and placed in the permanent file at the Department, shall be regarded as the lawful record of the event.

Historical Note
Former Section R9-19-110 repealed, new Section R9-19-110 renumbered from R9-19-118 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-111. Local registrars' responsibility to review death certificates for medical examiner referral
A. Each local registrar shall review death and fetal death certificates for individuals whose deaths occurred under circumstances set forth in A.R.S. § 11-593. If such certificate was not signed by the medical examiner and information on the certifi-

cate or other report indicates that death occurred under any of the circumstances listed in A.R.S. § 11-593, the local registrar shall immediately notify the nearest peace officer.

B. When a local registrar receives a death or fetal death certificate where the cause or manner of death or the circumstances surrounding the death should have been reported pursuant to A.R.S. § 11-593, and the medical examiner has not signed the death certificate, the local registrar shall not issue a disposal-transit permit until the deficiency is corrected.

C. Each local registrar shall review death and fetal death certificates when the remains are to be cremated. If the medical examiner has not signed the certificate as required under A.R.S. § 11-599, the local registrar shall not register the death and shall not issue a disposal-transit permit.

D. Any local registrar who receives and registers an improperly completed certificate and issues a disposal-transit permit in violation of this rule shall be subject to disciplinary action.

Historical Note

Former Section R9-19-111 renumbered to R9-19-105, new Section R9-19-111 renumbered from R9-19-119 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-112. Referral to medical examiner by State Registrar

When the State Registrar receives a death or fetal death certificate which has not been completed in accordance with R9-19-111, the matter shall be immediately referred to the medical examiner in whose district the death occurred. If the medical examiner declines to consider the matter or refuses to sign the certificate, the medical examiner shall notify the State Registrar in writing of the reasons therefor.

Historical Note

Amended effective February 20, 1980 (Supp. 80-1). Former Section R9-19-112 repealed, new Section R9-19-112 renumbered from R9-19-120 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-112.01. Amendments to Birth and Death Certificates by County Registrars

A. Prior to submitting a birth certificate to the State Registrar for assignment of a state file number, a county registrar may correct, amend or make additions to the entries on a birth certificate. All changes to a birth certificate shall be supported by documentation in accordance with R9-19-118(B) and (C) and R9-19-117.

B. Prior to submitting a death certificate to the State Registrar for assignment of a state file number, a county registrar may correct, amend or make additions to the entries on a death certificate except for the medical cause of death and the manner of death entries. All changes to a death certificate shall be supported by documentation in accordance with R9-19-119(B) and (C) and R9-19-117.

C. When a county registrar changes information originally entered on a birth or death certificate, a single line shall be drawn through the incorrect entry and the correct information written immediately above or as near the initial entry as practicable. The county registrar shall also enter a notation on a death certificate at "58. Supplementary entries" or on a birth certificate at "20. Supplementary entries" which specifies what information was changed, the date of the change and the initial of the county registrar.

D. When a county registrar adds information to a birth or death certificate which was previously omitted or missing, the information shall be typed in the appropriate spaces on the certificate and a notation explaining the addition entered on the back of the certificate.

E. When a county registrar corrects, amends or makes an addition to a birth or death certificate, the county registrar shall forward the documentary evidence supporting such correction, amendment or addition to the birth or death certificate to the State Registrar when transmitting the birth or death certificate in accordance with R9-19-109(3).

Historical Note

Adopted effective August 31, 1992 (Supp. 92-3). Amended effective March 4, 1993 (Supp. 93-1).

R9-19-113. Special circumstances for a new birth certificate; disposition of original birth certificate

A. An applicant may request that a new birth certificate be established by the State Registrar rather than amending an existing certificate under circumstances when an amendment would cause embarrassment or reflect adversely on the registrant or his parents or would substantially undermine the integrity and validity of the certificate.

1. An applicant may request that a new birth certificate be established for a minor child when the name of the father has been changed by a court order or in a naturalization proceeding.
2. Upon the filing of a request by both parents of a child born out of wedlock and an affidavit of acknowledgment of paternity, a new birth certificate may be established.

B. When a new birth certificate is created pursuant to this Section or A.R.S. § 36-326, the original birth certificate shall be replaced in the active files by the new birth certificate and the original birth certificate together with the evidence on which the new birth certificate was based shall be deposited in a sealed file. Access to the original certificate or release of information from it shall not be permitted except upon authorization of the State Registrar or by order of a court of competent jurisdiction.

Historical Note

Amended effective February 20, 1980 (Supp. 80-1). Former Section R9-19-113 renumbered to R9-19-106, new R9-19-113 renumbered from R9-19-132 and R9-19-133 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-114. Correction and amendment of vital records after official acceptance of certificate

No changes, corrections, additions, deletions or substitutions shall be made on any birth, death or fetal death certificate after the assignment of a state file number unless such alterations are fully documented according to law and these rules. All certificates on which judicial or major administrative changes are made shall be marked "certificate amended" unless otherwise provided by law. All certificates on which minor administrative changes are made after one year following the date of the event shall also be marked "certificate amended".

Historical Note

Amended effective February 20, 1980 (Supp. 80-1). Former Section R9-19-114 renumbered to R9-19-107, new R9-19-114 renumbered from R9-19-139 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-115. Classification of changes to correct or amend vital records

All changes on vital record forms shall be classified as follows:

1. Judicial changes - Any alterations, additions, deletions or substitutions relative to information originally entered

which are authorized by law or ordered by a court of competent jurisdiction.

2. Major administrative changes - Any non-judicial alterations, additions, deletions or substitutions relative to information originally entered which would materially affect the validity or integrity of a certificate or would substantially modify certain fundamental relationships on it.
3. Minor administrative changes - Any alterations, additions, deletions or substitutions relative to information originally entered which would not materially affect the validity or integrity of a certificate or would not substantially modify any fundamental relationship on it. Typographical and spelling errors and transposed letters are included in this category.

Historical Note
Former Section R9-19-115 renumbered to R9-19-108, new R9-19-115 renumbered from R9-19-140 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-116. Authority to request changes on certificate

A. A request for changes on a birth or fetal death certificate concerning any information except medical information and items relating to the burial of a fetus shall originate with the registrant or a parent or guardian if the registrant is a minor child. A request for change of medical information shall originate with the attendant or the hospital where the delivery took place. A request for change in information pertaining to burial or cremation shall originate with the funeral director.

B. A request for changes on a death certificate shall originate with the following:
1. A surviving spouse, parent or other close relative or the informant for identifying information or other personal particulars concerning the deceased;
2. The physician or pathologist, as provided in R9-19-310, in matters relating to the medical cause of death;
3. The medical examiner, as provided in R9-19-310, in matters relating to the manner and circumstances of death; or
4. The funeral director or person acting in such capacity, as provided in A.R.S. § 36-327(B), in matters relating to burial or other disposition of the body.

Historical Note
Former Section R9-19-116 renumbered to R9-19-109, new R9-19-116 renumbered from R9-19-141 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-117. Documentary evidence requirements

A. The following shall be required documentary evidence for each category of change on an existing vital record form:
1. Judicial changes - A certified copy of the certificate of adoption, order of adoption, judgment, court order or other legal instrument and any additional documents or information necessary to accomplish the desired changes.
2. Major administrative changes - An affidavit from the person requesting the change and one independent factual document corroborating the information to be corrected. If an independent factual document is not available or the information to be corrected is such that a factual document is not applicable, an affidavit of personal knowledge from a second individual may be substituted. The sufficiency of such affidavit is to be determined by the State Registrar who shall evaluate the accuracy, sufficiency, consistency and veracity of the document. The State Registrar shall decide which type of document or documents is acceptable in a particular care. For changes on a certificate initiated:
   a. Within one year from the date of the birth or death, the factual document shall have been established, in the case of a death, on or before the date of death or, in the case of a birth, within six months of the date of birth.
   b. Between one year and five years from the date of the birth or death, the factual document shall have been established at least one year prior to the date offered as evidence.
   c. Five years or more after the birth or death, the factual document shall have been established at least three years prior to the date offered as evidence and shall have been established during the first ten years of the registrant's life.
3. Minor administrative changes - An affidavit from the person requesting the change and such other evidence as the State Registrar shall deem necessary to establish the validity of the requested change. For changes requested within one year from the date of the birth or death, the affidavit alone shall suffice. For changes after one year, additional evidence shall be required.

B. The State Registrar may reject any document which does not satisfy any requirement of these rules, including one which is incomplete, fails to show the required information, conflicts with other information provided, shows signs of alteration or for which there is reasonable cause to believe the document is not authentic or truthful.

C. Documents furnished in connection with change or amendment or vital records shall be originals, certified photographic copies or authenticated abstracts. All documents, except the affidavit, shall be returned to the person requesting the change after review by the Department. Except as otherwise provided by law, reproductions of all documents shall be kept on file at the Department for at least three years following the date of the action and may be microfilmed for permanent retention.

Historical Note
Amended effective March 30, 1976 (Supp. 76-2).
Amended effective February 20, 1980 (Supp. 80-1).
Former Section R9-19-117 repealed, new Section R9-19-117 renumbered from R9-19-143 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-118. Changes on birth and fetal death certificates

A. Any changes of the following nature shall be judicial changes;
1. New birth certificate based on adoption, legitimation of paternity determination; or
2. Amendment of a birth certificate to show a change of name of the registrant by court order. All name changes after one year from the date of birth shall require a court order.

B. Any changes of the following items shall be major administrative changes:
1. Substantial alteration of the surname of the registrant not covered by judicial authorization;
2. Sex of the registrant due to surgical alterations of chromosomal counts;
3. Name of the registrant within one year from the date of the birth;
4. Name of either parent, except minor spelling errors;
5. Date or place of the birth;
6. Sex of child, type of birth or medical data relating to delivery and postnatal period;
7. Date or place of birth of either parent;
8. Marital status of the mother; or

9. Medical cause of death or related information of the fetal death certificate.
10. Addition of a father's name based upon sworn statements of paternity submitted by both parents.

C. All other changes to information, including all minor errors of spelling, typographical errors or correction of transposed letters, shall be minor administrative changes. When a child has not been named on a certificate at the time it is filed with the registrar, the name may be added within 90 days upon receipt of a written, notarized request signed by both parents. After 90 days the request shall be by an affidavit signed by both parents and supported by one factual document showing the requested name. After five years, a court order shall be required to add a name to the certificate. No fee shall be charged for adding only the child's name if done within one year from the date of birth.

Historical Note
Amended effective February 20, 1980 (Supp. 80-1). Former Section R9-19-118 renumbered to R9-19-110, new R9-19-118 renumbered from R9-19-144 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-119. Changes on death certificates

A. Any changes to death certificates of the following nature shall be judicial changes:
1. Amendment of a standard death certificate based on a declaration of death by a court of competent jurisdiction; or
2. Revision or alteration of the medical cause or the manner and circumstances of death based on the final determination of a court or a formal inquest.

B. Changes of the following items shall be major administrative changes:
1. Name of the deceased;
2. Race or sex of the deceased;
3. Date or place of death;
4. Marital status or name of the spouse;
5. Date or place of birth of the deceased;
6. Citizenship status of the deceased;
7. Medical cause of death;
8. Manner and circumstances of death; or
9. Entry in the certification statement of the physician or medical examiner.

C. All other changes of data, including all minor errors of spelling, typographical errors and transposed letters, shall be minor administrative changes.

Historical Note
Amended effective March 30, 1976 (Supp. 76-2). Former Section R9-19-119 renumbered to R9-19-111, new R9-19-119 renumbered from R9-19-145 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-120. Changes on a delayed birth certificate

Changes on a delayed birth certificate shall not be permitted except in the following instances:
1. Where a name has been changed by court order subsequent to the filing of the certificate, the new name may be shown on the certificate.
2. Where a person has been adopted subsequent to the filing of the certificate, a notation to that effect may be shown on the certificate in lieu of the issuance of a new birth certificate.
3. When, after review of the documentary evidence submitted, the State Registrar determines that there is incorrect information on the certificate due to an administrative or typographical error by the Office of Vital Records.

Historical Note
Amended effective March 30, 1976 (Supp. 76-2). Former Section R9-19-120 renumbered to R9-19-112, new R9-19-120 renumbered from R9-19-146 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-121. Repealed

Historical Note
Repealed effective July 31, 1989 (Supp. 89-3).

R9-19-122. Repealed

Historical Note
Amended effective February 20, 1980 (Supp. 80-1). Repealed effective July 31, 1989 (Supp. 89-3).

R9-19-123. Repealed

Historical Note
Repealed effective February 20, 1980 (Supp. 80-1).

R9-19-124. Repealed

Historical Note
Repealed effective February 20, 1980 (Supp. 80-1).

R9-19-125. Repealed

Historical Note
Repealed effective February 20, 1980 (Supp. 80-1).

R9-19-126. Repealed

Historical Note
Repealed effective February 20, 1980 (Supp. 80-1).

R9-19-127. Repealed

Historical Note
Repealed effective February 20, 1980 (Supp. 80-1).

R9-19-128. Repealed

Historical Note
Repealed effective February 20, 1980 (Supp. 80-1).

R9-19-129. Repealed

Historical Note
Repealed effective February 20, 1980 (Supp. 80-1).

R9-19-130. Repealed

Historical Note
Repealed effective February 20, 1980 (Supp. 80-1).

R9-19-131. Repealed

Historical Note
Repealed effective July 31, 1989 (Supp. 89-3).

R9-19-132. Renumbered

Historical Note
Former Section R9-19-132 renumbered to R9-19-113 effective July 31, 1989 (Supp. 89-3).

R9-19-133. Renumbered

Historical Note
Former Section R9-19-132 renumbered to R9-19-113 effective July 31, 1989 (Supp. 89-3).

R9-19-134. Renumbered

Historical Note
Former Section R9-19-134 renumbered to R9-19-310 effective July 31, 1989 (Supp. 89-3).

R9-19-135. Renumbered

Historical Note
Former Section R9-19-135 renumbered to R9-19-310 effective July 31, 1989 (Supp. 89-3).

R9-19-136. Renumbered

Historical Note
Former Section R9-19-136 renumbered to R9-19-310 effective July 31, 1989 (Supp. 89-3).

R9-19-137. Renumbered

Historical Note
Former Section R9-19-137 renumbered to R9-19-311 effective July 31, 1989 (Supp. 89-3).

R9-19-138. Repealed

Historical Note
Repealed effective February 20, 1980 (Supp. 80-1).

R9-19-139. Renumbered

Historical Note
Former Section R9-19-139 renumbered to R9-19-114 effective July 31, 1989 (Supp. 89-3).

R9-19-140. Renumbered

Historical Note
Former Section R9-19-140 renumbered to R9-19-115 effective July 31, 1989 (Supp. 89-3).

R9-19-141. Renumbered

Historical Note
Former Section R9-19-141 renumbered to R9-19-116 effective July 31, 1989 (Supp. 89-3).

R9-19-142. Repealed

Historical Note
Repealed effective July 31, 1989 (Supp. 89-3).

R9-19-143. Renumbered

Historical Note
Former Section R9-19-143 renumbered to R9-19-117 effective July 31, 1989 (Supp. 89-3).

R9-19-144. Renumbered

Historical Note
Former Section R9-19-144 renumbered to R9-19-118 effective July 31, 1989 (Supp. 89-3).

R9-19-145. Renumbered

Historical Note
Former Section R9-19-145 renumbered to R9-19-119 effective July 31, 1989 (Supp. 89-3).

R9-19-146. Renumbered

Historical Note
Former Section R9-19-146 renumbered to R9-19-120 effective July 31, 1989 (Supp. 89-3).

ARTICLE 2. DUTIES REGARDING LIVE BIRTHS

R9-19-201. Registration of live births

A. In addition to birth registration requirements specified in A.R.S. § 36-322, each hospital, clinic or other institution in the state providing regular maternity services shall furnish a monthly report to the State Registrar of all live births and of all registrable fetal deaths occurring in that facility for the preceding month. The report shall be sent to the State Registrar no later than the tenth day of the month following the period covered in the report and shall list the name of the child, date of birth and the name and address of the parents.

B. When, because of circumstances beyond its control, a hospital, clinic or other institution cannot file a birth certificate within the prescribed period, it shall notify the local registrar by telephone or letter of the reasons for the delay and the expected date of filing. If the delay extends beyond 14 days, a second notification shall be made to the local registrar. Such birth certificates shall be filed with the local registrar no later than 20 days after the date of birth whether or not it is complete.

C. When a physician, midwife or other person who delivers a child outside of a hospital, clinic or other institution is unable to file a birth certificate within the prescribed period of time, the local registrar shall be notified by telephone or letter, giving the name of the child, date of birth, name and address of the parents and the reason for the delay. Such birth certificate shall be filed no later than 20 days after the date of the birth.

Historical Note
Amended effective July 31, 1989 (Supp. 89-3).

R9-19-202. General requirements regarding late birth certificates

A late birth certificate registered within one year from date of the birth shall satisfy the following requirements:

1. The birth of the registrant occurred in Arizona as evidenced by one independent factual document establishing the mother's presence in Arizona at the time of birth;
2. The certificate shall be signed by a parent, relative or other person who can certify from personal knowledge of the date and place of birth, names of the parents and other facts required on the certificate.
3. The certificate shall be signed by the physician, midwife or other attendant who delivered the child. If the child was born in a hospital and the attending physician is no longer available, the hospital administrator or person in charge of medical records may sign instead and indicate his title; and
4. The certificate shall be registered by the local registrar of the district in which the birth occurred, unless exempted by law.

Historical Note
Amended effective July 31, 1989 (Supp. 89-3).

R9-19-203. Rejection of late birth certificates

When a late birth registration does not meet the requirements of R9-19-202, the State Registrar shall reject the certificate.

Historical Note
Former Section R9-19-203 repealed, new Section R9-19-203 renumbered from R9-19-204 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-204. Form of late birth certificate; fee

A. All late birth registrations shall be on the standard certificate of live birth form in current use at the time the record is filed.

B. No filing fee shall be charged for a late birth certificate.

Historical Note
Former Section R9-19-204 renumbered to R9-19-203, new Section R9-19-204 renumbered from R9-19-205 effective July 31, 1989 (Supp. 89-3).

R9-19-205. Application for delayed birth registration

A. Any person born in Arizona who is older than one year and whose birth has not previously been registered can apply to the State Registrar for a delayed birth certificate, except that an application shall not be accepted for a deceased person. Persons whose late birth registration is rejected under R9-19-203 may apply for a delayed birth certificate. The application fee shall be paid at the time of formal application.

B. The application shall be pending until completed or until one year has elapsed from the date of application, whichever is earlier. The date the fee is paid shall be considered the date of formal application. After one year from the date of application all uncompleted registrations shall lapse and the fees forfeited.

C. Any applicant who voluntarily withdraws his request before the lapse date shall be entitled to a full refund. No refund will be made after an application has lapsed.

Historical Note
Amended effective February 20, 1980 (Supp. 80-1).
Former Section R9-19-205 renumbered to R9-19-204, new Section R9-19-205 renumbered from R9-19-206 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-206. General requirements for delayed birth registration

A. The facts regarding a delayed birth registration shall be recorded on a form provided by the State Registrar for that purpose.

B. The following data concerning the registrant shall be shown on the delayed birth certificate:
1. Full name at birth. Where a person, whose birth is to be registered, has undergone a change of name through adoption, legitimation or other court action prior to application for delayed registration, the person, whose birth is to be registered, may choose to have the new name shown;
2. Date of birth -- month, day and year;
3. Sex;
4. Race or color;
5. Place of birth -- town or city and county;
6. Names of parents. If a registrant has been adopted, the names of adoptive parents may be shown; and
7. Information required by the State Registrar in order to comply with federal or state laws, rules or regulations or federal document guidelines.

C. Each delayed certificate of birth shall be signed by the person whose birth is to be registered and sworn to before an official authorized to administer oaths, provided that such person is 18 years of age or over and is competent to sign and swear to the accuracy of the facts stated therein. Otherwise the certificate shall be signed and sworn to by one of the following in the indicated order of priority:
1. One of the parents of the person whose birth is to be registered;
2. The legal guardian of the person whose birth is to be registered; or
3. The next of kin of the person whose birth is to be registered.

Historical Note
Amended effective February 20, 1980 (Supp. 80-1).
Amended effective February 20, 1980 (Supp. 80-1).
Former Section R9-19-206 renumbered to R9-19-205, new Section R9-19-206 renumbered from R9-19-207 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-207. Documentary requirements for delayed birth registration

A. If the person is between one and fourteen years of age, the following documents shall be submitted:
1. An affidavit attesting to the facts of birth from the father, mother or other family member having personal knowledge of the birth;
2. One independent factual document attesting to the facts of birth established prior to the person reaching age five; and
3. One independent factual document establishing the mother's presence in Arizona at the time of birth.

B. If the person is 15 years of age or older, the following documents shall be submitted:
1. An affidavit attesting to the facts of birth from the mother, father, a relative or other individual at least ten years older than the person and who has personal knowledge of the birth; and
2. Two factual supporting documents attesting to the facts of birth independently established at least five years prior to the date on which offered as evidence, at least one of which was established during the first ten years of the person's life; and
3. One independent factual document establishing the mother's presence in Arizona at the time of birth.

C. The full name of the person and the date and place of birth shall be evidenced in each of the required documents. All other birth facts, including the names of the parents, shall be clearly supported by at least one document. A document established before the person's fourth birthday shall be preferred over later ones. A factual document may be substituted for an affidavit, provided it contains the necessary information.

D. A summary statement of the documentary evidence submitted in support of a delayed birth certificate shall be written on the face of the form. The date of registration shall also be entered and the signature of the State Registrar shall signify official acceptance of the certificate.

E. The State Registrar shall determine the acceptability of all documents submitted by an applicant. The State Registrar shall reject any document judged to be inadequate, unsatisfactory, conflicting, or in any manner not in compliance with these rules, and require an additional document. The State Registrar shall not register a delayed birth certificate if no combination of documents shows the minimum required information, if the documents do not agree as to the facts, or if the State Registrar has reasonable cause to question the validity, adequacy, or consistency of the certificate or documentary evidence. The State Registrar shall apprise the applicant of such refusal and the reasons therefor. The State Registrar shall consider the acceptability of the group as a whole and shall require additional documentation until the minimum requirements are met.

F. Documents furnished in connection with a delayed birth certificate shall be originals, certified photographic copies or

authenticated abstracts. The State Registrar shall refuse any document showing alterations, erasures or substitutions of information. All documents shall be returned to the sender after review. Reproductions of all documentary evidence shall be kept on file at the Department for at least three years following the date of the registration and may be microfilmed for permanent retention.

Historical Note

Amended effective February 20, 1980 (Supp. 80-1).
Former Section R9-19-207 renumbered to R9-19-206,
new Section R9-19-207 renumbered from R9-19-208 and
amended effective July 31, 1989 (Supp. 89-3).

R9-19-208. Cancellation of a delayed birth certificate; duties of State Registrar

A. The State Registrar shall cancel a delayed birth certificate upon evidence of the following:
1. That an original birth certificate for the registrant already exists in the files of the Department; or
2. That a delayed birth certificate was established through fraud, misrepresentation of the facts or was based on false documents.

B. The State Registrar shall advise a registrant by certified mail of the cancellation of a delayed birth certificate. The registrant may appeal such action through the exercise of available statutorily-defined administrative remedies.

Historical Note

Adopted effective February 20, 1980 (Supp. 80-1).
Former Section R9-19-208 renumbered to R9-19-207,
new Section R9-19-208 renumbered from R9-19-209 and
amended effective July 31, 1989 (Supp. 89-3).

R9-19-209. Renumbered

Historical Note

Former Section R9-19-209 renumbered to R9-19-208
effective July 31, 1989 (Supp. 89-3).

ARTICLE 3. DUTIES OF PERSONS RESPONSIBLE FOR DEATH RECORDS; POST-MORTEM PROCEDURES

R9-19-301. Completion of medical cause of death and manner of death sections of death certificate

A. The physician who treated a patient or was in charge of the patient's care for the illness or condition which resulted in death shall complete and sign the medical certification of cause of death promptly so that funeral arrangements may be made. The entries shall be legibly written using only terms in accepted medical usage. Indefinite or obsolete terms which denote only symptoms of a disease or conditions resulting from a disease shall be sufficient grounds for the local registrar to refuse to accept the certificate and not issue a disposal-transit permit. Statements of cause of death which are clearly illogical, confusingly written, expressed in abbreviations or "shorthand" shall not be accepted.
1. Part I of the medical statement of cause of death shall contain only the disease sequence, injury or other trauma which directly resulted in the person's death. The immediate cause of death shall be written on line A. If there are antecedent causes, they shall be written on lines B and C, with the intermediate cause on line B and the underlying cause on line C. The underlying cause shall be the last cause listed. If there is no intermediate cause, then the underlying cause shall be entered on line B. In instances where the immediate cause and the underlying cause are synonymous, only the one entry is necessary.
2. Part II of the medical statement of the cause of death shall contain diseases, injuries or other factors of significant medical or statistical importance not directly related to the cause of death. In those cases where the physician cannot be certain, best judgment shall be exercised in assigning entries to Part I or Part II of the medical statement of cause of death.

B. When a physician cannot certify within 72 hours after the time of death as to the cause of death pending the results of a post-mortem examination, laboratory tests or other factors beyond the physician's control, the physician shall enter "pending further examination" on the death certificate and sign it. Such certificate shall be acceptable for the local registrar to issue a disposal-transit permit. No later than ten days after the date of death, the physician shall forward a supplementary certificate of cause of death to the State Registrar. Such certificate shall be completed in accordance with R9-19-310 et seq.

C. When the medical examiner cannot complete and sign the death certificate within 72 hours, the words "pending further investigation" shall be entered on the death certificate and the certificate shall be signed. A death certificate so completed shall be valid for the local registrar to issue a disposal-transit permit, but possession of the permit shall not relieve the funeral director from obtaining full release from the medical examiner before final disposition of the body. Under no circumstances shall a body under the medical examiner's jurisdiction be cremated or removed from the state until both the medical cause and the manner of death have been determined or the medical examiner has otherwise released the body for such disposition. In the latter instance, a written statement from the medical examiner authorizing disposition of the body shall be delivered to the local registrar before a disposal-transit permit will be issued.

D. When the medical examiner cannot certify the medical cause and the manner of death within the time set forth in Subsection (C) of this rule, a supplementary certificate of cause of death shall be completed and filed with the Department as soon as possible, but no later than 20 days after the date of death. Such certificate shall be completed in accordance with R9-19-310 et seq. and shall set forth both the medical cause and the manner of death and contain such other information as required by law, these rules or forms supplied by the State Registrar.

Historical Note

Amended effective March 30, 1976 (Supp. 76-2).
Amended effective February 20, 1980 (Supp. 80-1).
Amended effective July 31, 1989 (Supp. 89-3).

R9-19-302. Registration of a fetal death certificate and reporting of abortional acts

A. For purposes of preparing fetal death certificates, if the gestation period is uncertain or unknown, a certificate should be filed if the fetus weighs 350 grams or more. Any abortional act resulting in a fetal death when the length of gestation is more than 20 weeks shall also require the filing of a fetal death certificate.

B. A termination of pregnancy report shall be prepared by the attending physician and filed directly with the State Registrar reporting any fetal death due to an abortional act for which a fetal death certificate is not required. Such reports shall be confidential and disclosable by the Department only in aggregate form for statistical or research purposes. No personally identifiable patient information or information relating to any physician, hospital, clinic or other institution shall be released for any purpose. The termination of pregnancy report shall be prepared on forms prescribed and furnished by the State Registrar.

C. Each hospital and outpatient treatment center in the state shall submit a monthly report to the State Registrar showing:
1. All registrable fetal deaths occurring in that facility in accordance with R9-19-201; and
2. The total number of abortional acts performed in that facility.

If no registrable fetal deaths or abortional acts occurred in the facility during the month, no report need be sent.

D. The monthly reports required by this rule shall be confidential and disclosable by the Department only in aggregate form for statistical or research purposes. No personally identifiable patient information or information relating to any physician, hospital, clinic or other institution shall be released for any purpose.

E. When a registrable fetal death occurs outside a hospital and is not attended by a physician, the medical examiner shall sign the fetal death certificate.

F. When a fetal death has not been registered within one year from the date of occurrence, the certificate shall be filed directly with the State Registrar. Local registrars receiving such certificates shall forward them immediately to the State Registrar and shall not enter them in the local registers.

Historical Note
Amended effective March 30, 1976 (Supp. 76-2).
Amended effective February 20, 1980 (Supp. 80-1).
Amended effective July 31, 1989 (Supp. 89-3).

R9-19-303. Provisional death certificates

When it is necessary to ship a body out of the state less than 24 hours after death and the funeral director cannot file a complete death certificate in time to obtain a disposal-transit permit, a provisional certificate may be filed which contains, at a minimum, the name of the deceased, the date and place of death, the medical cause of death and the destination. Such certificate shall be marked "provisional" and shall be accompanied by a signed form stating that a completed death certificate will be filed within six days after the date of death. The local registrar shall retain the provisional death certificate in a special file until the complete record is filed whereupon the provisional record shall be destroyed.
1. This procedure shall be used only with deaths due to natural causes; and
2. This procedure shall be used only in unusual or emergency situations and its use will be carefully monitored by the State Registrar.

Historical Note
Amended effective July 31, 1989 (Supp. 89-3).

R9-19-304. Requirements for late death certificates

The requirements for a late death or a late fetal death certificate shall be the same as for certificates registered within the three-day period except that the State Registrar or local registrar may require sworn statements or other documentary evidence to support any entry shown on a certificate in order to protect the evidentiary value of the record. Late death or fetal death certificates delivered to a local registrar more than 90 days after the date of death shall be forwarded immediately to the State Registrar and not entered in the local register. A summary statement of any documentary evidence required shall be written on the certificate along with a notation that it has been reviewed by the State Registrar. The notation "late death registration" or "late fetal death registration" shall also be entered in a prominent place on the record. Late death and late fetal death certificates shall be filed within one year of the date of death.

Historical Note
Amended effective July 31, 1989 (Supp. 89-3).

R9-19-305. Requirements for death certificates based on court determination of death

A. When a person is declared dead by an order of a Superior Court of this state, the State Registrar is authorized to create a standard death certificate based on the determination set forth in the court order. The death certificate shall contain the following information.
1. Name and other personal data concerning the deceased;
2. Date or approximate date of death and place where death is believed to have occurred;
3. Brief statement of circumstances of death insofar as known; and
4. Citation of the court order.

B. A certified copy of the court order shall be submitted to the State Registrar by the person or official requesting the death certificate. The State Registrar may require such additional information as may be necessary in order to complete the death certificate. A certificate so established shall have the same status as other death certificates and certified copies may be issued to any qualified applicant.

Historical Note
Former Section R9-19-305 repealed, new Section R9-19-305 adopted effective February 20, 1980 (Supp. 80-1).
Amended effective July 31, 1989 (Supp. 89-3).

R9-19-306. Finding a body or person after court determination of death

A. In the event that the body of the deceased person is found and identified after a court determination of death, a regular death certificate shall be filed with the State Registrar under established procedures, whereupon the certificate created on the basis of the court order shall be placed in a sealed file and not opened to further inspection, except as provided by rule or by order of the court.

B. In the event that information is received which gives the State Registrar reasonable cause to believe that a person previously declared dead by the court is alive, the State Registrar shall promptly inform the court of such information and recommend to such person to apply to the court to reconsider the matter. If the court subsequently finds that an individual who was previously declared dead by the court is alive, the certificate created from the earlier court order shall be placed in a sealed file and not opened for further inspection except as provided by rule or by order of the court.

Historical Note
Former Section R9-19-306 renumbered as Section R9-19-308, new Section R9-19-306 adopted effective February 20, 1980 (Supp. 80-1). Amended effective July 31, 1989 (Supp. 89-3).

R9-19-307. Requirements for delayed death certificates

A. A delayed death or delayed fetal death certificate shall be prepared on the form in use at the time the certificate is filed and shall be filed directly with the State Registrar in all cases. The authorized fee shall be paid at the time the applicant files the certificate. The certificate shall contain the following information:
1. Full name of deceased, sex, race, age at time of death and place of residence at time of death;
2. The place of death and date of death or approximate date if the actual date is not known;
3. The medical cause of death insofar as can be determined and whether death was due to accident, suicide, homicide or natural causes; and

4. Manner of final disposition of body and place where buried, cremated or reinterred.

B. The State Registrar shall require sworn statements from individuals or certified abstracts of any records which, in the judgment of the State Registrar, are necessary to support the information shown on the certificate itself. A summary statement of documentary evidence shall be written on the certificate together with a notation that it has been reviewed by the State Registrar. The notation "delayed death registration" or "delayed fetal death registration" shall be entered in a prominent place on the certificate.

Historical Note

Former Section R9-19-307 renumbered as Section R9-19-309, new Section R9-19-307 adopted effective February 20, 1980 (Supp. 80-1). Amended effective July 31, 1989 (Supp. 89-3).

R9-19-308. Exception

Late death and delayed death registration procedures shall not be used in cases where the bodies of missing persons are discovered, regardless of the elapsed time between discovery and date of presumed death. For the purposes of the death or fetal death certificate, the date of death shall be considered as the date the remains were initially found and the death certificates shall be so marked. The date of presumed death shall be written on the certificate or on a supplementary report as additional information.

Historical Note

Adopted effective March 30, 1976 (Supp. 76-2). Former Section R9-19-308 renumbered and amended as Section R9-19-310, former Section R9-19-306 renumbered as Section R9-19-308 effective February 20, 1980 (Supp. 80-1). Amended effective July 31, 1989 (Supp. 89-3).

R9-19-309. Supporting statements

The State Registrar shall require sworn statements from individuals or abstracts of any records which, in the judgment of the State Registrar, are necessary to support the information shown on a death certificate.

Historical Note

Former Section R9-19-309 renumbered and amended as Section R9-19-311, former Section R9-19-307 renumbered as Section R9-19-309 effective February 20, 1980 (Supp. 80-1). Amended effective July 31, 1989 (Supp. 89-3).

R9-19-310. Supplementary certificates of cause of death; medical personnel who may initiate changes on death certificate

A. No changes, additions or deletions of information on a death certificate which alter the medical cause of death or the manner and circumstances of death shall be permitted unless entered on a supplementary certificate of cause of death. The supplementary certificate shall be attached to and made a part of the original certificate. Appropriate notation shall be made on the original certificate as to what changes were made and upon what evidence.

B. A request for a change as to the medical cause of death shall be considered only if it originates with one of the following:
1. The physician who originally signed the death certificate;
2. A pathologist who has performed a post-mortem examination and as a result of such examination has found reason to change the cause of death as previously listed. Such request shall be with the knowledge and consent of the physician who originally signed the death certificate; or
3. A supervising physician of a county, state or federal hospital responsible for and acting on behalf of junior staff physicians who regularly see and treat patients under the jurisdiction of that institution.

C. Changes as to the manner and circumstances of death on a death certificate shall originate with the medical examiner who initially signed the death certificate or another medical examiner authorized by law and having access to the official files of the case and shall be entered on a supplementary certificate of cause of death.

D. The medical examiner shall submit a signed, supplementary certificate of cause of death for changes under the following circumstances:
1. When changes are made in the medical statement of the cause of death because of additional information gained through an autopsy;
2. Where the medical examiner was not able to indicate the manner and circumstances of death on the original death certificate because information on the medical cause of death was not initially available; or
3. When the results of a court proceeding, findings of an inquest or other delayed source of information indicates to the medical examiner the need for a change as to the manner or circumstances of death.

E. Changes in the medical cause of death shall be certified by the medical examiner.

Historical Note

Adopted effective March 30, 1976 (Supp. 76-2). Former Section R9-19-310 renumbered and amended as Section R9-19-312, former Section R9-19-308 renumbered and amended as Section R9-19-310 effective February 20, 1980 (Supp. 80-1). Editorial correction, Paragraph (2) (Supp. 80-2). Former Section R9-19-310 renumbered to R9-19-312, new R9-19-310 renumbered from R9-19-134, R9-19-135 and R9-19-136 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-311. Transmittal of supplementary certificates of death

Supplementary certificates of cause of death, completed and signed by the responsible officials, shall be forwarded to the State Registrar as soon as possible and not later than the maximum time allowed in R9-19-301. In all other cases, supplementary certificates shall be forwarded as soon as the attending physician or the medical examiner has sufficient additional information upon which to base a determination or amendment of the cause of death or manner or circumstances of death.

Historical Note

Former Section R9-19-311 renumbered as Section R9-19-313, former Section R9-19-309 renumbered and amended as Section R9-19-311 effective February 20, 1980 (Supp. 80-1). Former Section R9-19-311 renumbered to R9-19-313, new Section R9-19-311 renumbered from Section R9-19-137 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-312. Preservation of bodies; general

The body of any person who has died in this state, including a fetus of 20 completed weeks or more gestation, shall not be held at a temperature above 38° Fahrenheit for a total period of time of more than 24 hours between the time of death and final disposition unless embalmed.

1. Embalming
   a. Except as otherwise provided in R9-19-313 and R9-19-326, embalming shall not be performed unless

authorized by the family, next of kin, personal representative or other person assuming responsibility for final disposition.

b. When death is from an unknown cause of there are reasonable grounds to suspect that a crime has been committed, a body shall not be embalmed until the medical examiner has authorized such action.

c. All embalming operations shall be in accordance with the laws of the state and rules of the State Funeral Directors and Embalmers Board.

2. Bodies in vaults

a. A body kept in a private or public vault, including a receiving vault, longer than 15 days shall be placed in an airtight casket or other container. This provision does not apply to bodies kept in mausoleums or other places of final disposition where aeration or dehydration processes are used.

b. A body kept in a receiving vault longer than 30 days shall be regarded as interred. At such time as it is further buried, cremated or removed, a disinterment permit shall be obtained.

Historical Note

Amended effective March 30, 1976 (Supp. 76-2). Former Section R9-19-312 renumbered as Section R9-19-316, former Section R9-19-310 renumbered and amended as Section R9-19-312 effective February 20, 1980 (Supp. 80-1). Former Section R9-19-312 renumbered to R9-19-314, new Section R9-19-312 renumbered from Section R9-19-310 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-313. Preservation when death caused by certain diseases

A. The body of a person who died from cholera, diphtheria, infectious tuberculosis, plague, actual or suspected smallpox, yellow fever, actual or suspected viral hemorrhagic fevers (Lassa, Marburg, Ebola or Congo-Crimean) or other such viral hemorrhagic fevers that may be later identified shall not be transported within or outside the state either by private or commercial transportation unless the body has been embalmed in accordance with procedures of the State Funeral Directors and Embalmers Board and placed in a hermetically sealed casket or metal lined container. The casket or container shall not be opened while in transit. The funeral director in charge of the body shall abide by any special instructions from the state or local health authorities.

B. Any hospital or physician caring for a patient who dies from a disease listed in Subsection (A) above shall immediately notify the state and local health departments. The funeral director who takes charge of the body shall also be notified of the cause of death.

Historical Note

Amended effective March 30, 1976 (Supp. 76-2). Former Section R9-19-313 renumbered as Section R9-19-317, former Section R9-19-311 renumbered as Section R9-19-313 effective February 20, 1980 (Supp. 80-1). Former Section R9-19-313 renumbered to R9-19-315, new Section R9-19-313 renumbered from Section R9-19-311 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-314. Disposition of bodies

A. A body shall not be cremated until the medical examiner has issued a certificate pursuant to A.R.S. § 11-599.

B. A body shall not be interred, cremated, held or stored in any place not properly reserved or designated for such purpose.

C. A body stored under conditions of very low temperature shall be regarded as interred. At such time as it is further buried, cremated or removed, a disinterment permit shall be obtained.

D. When a fetal death of less than 20 weeks of gestation occurs in an institution, the fetal remains may be disposed of in any manner which does not constitute a menace to public health, provided that it is done in compliance with A.R.S. § 36-331(B).

E. No restrictions shall be imposed by these rules on the disposition of amputated limbs or other body tissue of persons still living and these events are not registrable under the vital statistics law or rules.

F. A coffin or casket is not required for the interment of dead human remains, except as otherwise provided in Sections R9-19-312; R9-19-313; or R9-19-326.

Historical Note

Former Section R9-19-314 renumbered and amended as Section R9-19-318, new Section R9-19-314 adopted effective February 20, 1980 (Supp. 80-1). Former Section R9-19-314 renumbered to R9-19-316, new Section R9-19-314 renumbered from Section R9-19-312 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-315. Procedures in event of disaster

In the event of a disaster or other major emergency where it would be impractical to observe these rules for controlling the preparation, transportation and disposition of the dead, these rules shall be superseded for the duration of the emergency by such directives as the governor of the state or any duly appointed disaster authority may issue.

Historical Note

Former Section R9-19-315 renumbered as Section R9-19-319, new Section R9-19-315 adopted effective February 20, 1980 (Supp. 80-1). Former Section R9-19-315 renumbered to R9-19-317, new Section R9-19-315 renumbered from Section R9-19-313 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-316. Responsibilities of persons in charge of cemeteries or crematories

A. The manager of every regularly organized cemetery or crematory shall keep a record of all interments or cremations occurring in such establishment. Such records shall show the name of the deceased, the date and place of death and the name and address of the funeral director or person in charge. Such records shall be subject to inspection by the State Registrar or authorized representative.

B. No cemetery shall permit the interment or cremation of a body unless accompanied by a properly completed disposal-transit permit.

C. No crematory shall permit the cremation of a body unless accompanied by a properly completed disposal-transit permit.

Historical Note

Former Section R9-19-316 renumbered as Section R9-19-320, former Section R9-19-312 renumbered as Section R9-19-316 effective February 20, 1980 (Supp. 80-1). Former Section R9-19-316 renumbered to R9-19-318, new Section R9-19-316 renumbered from Section R9-19-314 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-317. Requirements for preparation and filing of disposal-transit permits

The disposal-transit permit shall contain the following information and be fully completed before filing:

1. The name, sex, age and race of the deceased; the date and place of death; the manner of disposition and the funeral establishment responsible for final disposition;
2. The cause of death if the body is to be shipped by commercial or common carrier or is to be moved out of the state, except as otherwise provided in this Article when released for disposition by the medical examiner. The cause of death shall also be specified if the person died from any of the communicable diseases enumerated in R9-19-313;
3. The signature of the funeral director and the local registrar; and
4. The location of interment or other disposition and the signature of the person in charge of the location of interment or other place of disposition.

Historical Note

Former Section R9-19-317 renumbered as Section R9-19-321, former Section R9-19-313 renumbered as Section R9-19-317 effective February 20, 1980 (Supp. 80-1). Former Section R9-19-317 renumbered to R9-19-319, new Section R9-19-317 renumbered from Section R9-19-315 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-318. Disposal-transit permit required

The body of a person who has died or is found dead in Arizona, including a fetus which has completed the 20th week of gestation, shall not be buried, deposited in a vault, cremated, held more than three days after death or removed from the registration district where death occurred without a funeral director or a person acting in such capacity first obtaining a disposal-transit permit from the local registrar of that district. An appropriate death or fetal death certificate shall be filed with the local registrar before the disposal-transit permit shall be issued, except as provided in R9-19-319, R9-19-322, R9-19-323 and R9-19-324(B).

1. A disposal-transit permit issued by any local registrar shall be valid for disposition of the remains in any registration district of this state or for removal outside the state.
2. A crematory shall not accept a body or fetus for cremation unless the accompanying disposal-transit permit and the certificate specifically authorize cremation.
3. Under no circumstances shall a body or fetus be cremated or transported out of the state unless accompanied by a properly completed disposal-transit permit authorizing such action. A death certificate shall be filed before the permit can be issued.
4. If at the time of death the decedent was infected with a disease listed in R9-19-313, the local registrar shall notify the state and local health authorities before issuing a disposal-transit permit.
5. No fee shall be collected for issuing a disposal-transit permit.

Historical Note

Amended effective March 30, 1976 (Supp. 76-2). Former Section R9-19-318 renumbered as Section R9-19-322, former Section R9-19-314 renumbered and amended as Section R9-19-318 effective February 20, 1980 (Supp. 80-1). Former Section R9-19-318 renumbered to R9-19-320, new Section R9-19-318 renumbered from Section R9-19-316 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-319. The disposal-transit permit; exceptions

A. A body or fetus may be moved outside a registration district for preparation for burial without disposal-transit permit when facilities for such preparation are not available at the place of death and upon notification of the local registrar of the removal.

B. Upon order of the medical examiner, a body may be moved to another registration district for an autopsy or other investigation without a disposal-transit permit following notification of the local registrar.

Historical Note

Amended effective March 30, 1976 (Supp. 76-2). Former Section R9-19-319 renumbered as Section R9-19-324, former Section R9-19-315 renumbered as Section R9-19-319 effective February 20, 1980 (Supp. 80-1). Former Section R9-19-319 renumbered to R9-19-321, new Section R9-19-319 renumbered from Section R9-19-317 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-320. Bodies from out-of-state

When a body is transported into Arizona from outside of the state, the local registrar of the district where the body is to be buried shall issue a new disposal-transit permit noting the place where death occurred, the type of final disposition and the place where shipment originated. If the remains are disinterred remains, that fact shall also be indicated by entering "disinterred remains" on the disposal-transit permit. The permit from the state of origin shall be mailed promptly to the Department. Bodies thus brought into the state shall not be held longer than three days without the reissuance of a disposal-transit permit.

Historical Note

Former Section R9-19-320 renumbered as Section R9-19-325, former Section R9-19-316 renumbered as Section R9-19-320 effective February 20, 1980 (Supp. 80-1). Former Section R9-19-320 renumbered to R9-19-322, new Section R9-19-320 renumbered from Section R9-19-318 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-321. Attachment of disposal-transit permit while in transit

When a body is transported by private, commercial or common carrier, the disposal-transit permit shall be placed in a strong heavy-duty envelope and securely attached to the shipping container in a conspicuous place. A private, commercial or common carrier shall not accept a body for shipment unless accompanied by a disposal-transit permit and no body shall be transported into, through or out of the state without such permit.

Historical Note

Amended effective March 30, 1976 (Supp. 76-2). Former Section R9-19-321 renumbered as Section R9-19-326, former Section R9-19-317 renumbered as Section R9-19-321 effective February 20, 1980 (Supp. 80-1). Former Section R9-19-321 renumbered to R9-19-323, new Section R9-19-321 renumbered from Section R9-19-319 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-322. Pre-signed disposal-transit permits

A. Upon approval of the State Registrar, local registrars may deliver pre-signed disposal-transit permits to funeral directors in their jurisdictions. When a funeral director having pre-signed permits takes charge of a body, the funeral director shall telephone the local registrar and give the name of the deceased, sex, age, date and place of death, cause of death and place of interment. The local registrar shall enter this information in the register book and give the funeral director a file number which shall be entered in the designated place on the disposal-transit permit. The funeral director may then proceed with funeral arrangements and disposition of the body but

shall file the death certificate either in person or by mail within three days. A certificate shall be considered filed on time if the letter is postmarked within three days from date of death.

B. This procedure may be used only with deaths from natural causes and shall not be used in any case where the body is being cremated or shipped out of the state.

C. A funeral director who fails to file certificates on time or who otherwise violates or abuses this procedure shall not be permitted to continue to utilize it.

Historical Note

Former Section R9-19-322 renumbered as Section R9-19-328, former Section R9-19-318 renumbered as Section R9-19-322 effective February 20, 1980 (Supp. 80-1). Former Section R9-19-322 renumbered to R9-19-324, new Section R9-19-322 renumbered from Section R9-19-320 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-323. Extension of time for filing death certificate

When a funeral director has obtained a disposal-transit permit prior to filing a death certificate and is unable to file the certificate within the specified time, the funeral director shall contact the local registrar by telephone for approval of an extension of time. No more than two extensions will be allowed and the certificate shall be filed with the local registrar, in all cases, no later than six days following the date of death.

Historical Note

Former Section R9-19-323 renumbered as Section R9-19-331, new Section R9-19-323 adopted effective February 20, 1980 (Supp. 80-1). Former Section R9-19-323 renumbered to R9-19-325, new Section R9-19-323 renumbered from Section R9-19-321 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-324. Special situations regarding disposal-transit permits

A. A disposal-transit permit may be issued under emergency conditions when a body is to be shipped out-of-state less than 24 hours after death. A provisional death certificate shall be filed as provided in R9-19-303 before the permit can be issued.

B. Under circumstances where a body has been moved outside a registration district or more than 50 miles from the place of death without a disposal-transit permit pursuant to R9-19-319, the funeral director may elect to file the death certificate with and obtain a disposal-transit permit from the nearest local registrar. The local registrar shall note the facts in the register and shall not register the certificate, but rather it shall be forwarded to the registrar of the district where death occurred for proper registration.

C. In case of an emergency or the unavoidable absence of a local registrar, a clerk of a county board of supervisors or official of a local health department shall be authorized to accept a death certificate and issue a disposal-transit permit. The death certificate and duplicate copy of the disposal-transit permit shall be delivered to the local registrar upon his return.

Historical Note

Former Section R9-19-324 renumbered as Section R9-19-332, former Section R9-19-319 renumbered as Section R9-19-324 effective February 20, 1980 (Supp. 80-1). Former Section R9-19-324 renumbered to R9-19-326, new Section R9-19-324 renumbered from Section R9-19-322 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-325. Transmittal procedures for permit

The disposal-transit permit shall consist of four copies. The "transit copy" shall accompany the body to the place of burial or other disposition. The "local registrar copy" shall be retained by the local registrar issuing the permit. The "transport copy" shall be retained for the transportation company's use. The "state copy" shall be immediately mailed by the funeral director to the State Registrar where it shall serve as official notification that a death has occurred. Upon final disposition, the person in charge of the cemetery or crematory shall enter the appropriate signature on the transit copy and mail it to the State Registrar within ten days. When interment is in a place where there is no person in charge, the funeral director handling the interment shall write across the permit "no person in charge", sign his name and mail the permit to the State Registrar within ten days. Local registrars shall retain file copies of disposal-transit permits for two years from the date of issue.

Historical Note

Former Section R9-19-325 repealed, former Section R9-19-320 renumbered as Section R9-19-325 effective February 20, 1980 (Supp. 80-1). Former Section R9-19-325 renumbered to R9-19-327, new Section R9-19-325 renumbered from Section R9-19-323 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-326. Container requirements for transportation of bodies and disinterred remains

A. Except as provided in subsection (D) below, a body transported outside the boundaries of the state by a private, commercial or common carrier shall be embalmed by an approved process and enclosed in a container suitable to the type of transportation used. The body need not be placed in a casket if the shipping container affords reasonable protection against transportation damage, allows no escape of body fluids or offensive odors and does not expose any person to risk of infection or other health hazards. An additional container may be used if the transportation agency requires it and the distance to be traveled makes this advisable.

B. Bodies moved within the state under the supervision of a licensed funeral director in vehicles normally used for that purpose may be transported in any manner requested by the family of the deceased which will not expose any person to a health hazard. No special container requirements are mandatory. Persons who are not licensed funeral directors may transport a body within the state by private conveyance for burial on privately-owned or non-commercial property, provided the elapsed time between the issuance of the disposal-transit permit and the time of disposition does not exceed 36 hours. If the body is held longer than 24 hours before burial, the provisions of R9-19-312 regarding embalming shall apply. All requirements regarding death certificates and disposal-transit permits shall be satisfied before the body is removed from the registration district where death occurred.

C. Special consideration shall be extended to the transportation of bodies pursuant to Title 36, Chapter 7, Article 1, of the Arizona Revised Statutes, and these rules shall be applied, so as to expedite the removal of bodies to any point designated by the Department, provided that such actions do not produce or promote conditions dangerous to the health of the public or to the persons engaged in the removal.

D. Bodies may be removed from the state without having been embalmed if transportation is provided by an immediate family member of the decedent or by a licensed funeral director who shall handle disposition of the body at the point of destination, and provided that such removal shall be made within 24 hours following death.

Historical Note

Former Section R9-19-326 renumbered and amended as Section R9-19-334, former Section R9-19-321 renum-

bered as Section R9-19-326 effective February 20, 1980 (Supp. 80-1). Former Section R9-19-326 renumbered to R9-19-328, new Section R9-19-326 renumbered from Section R9-19-324 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-327. Shipment of disinterred or cremated remains

A. Disinterred remains shipped from any point in the state by commercial carrier shall be placed in a metal-lined container, which is hermetically sealed.

B. No disinterred remains shall be shipped into, through or out of the state without a disinterment permit.

C. When a permit is requested to move cremated remains outside the state, either a disposal-transit or disinterment permit shall be used.

Historical Note

Adopted effective February 20, 1980 (Supp. 80-1). Former Section R9-19-327 renumbered to R9-19-329, new Section R9-19-327 renumbered from Section R9-19-325 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-328. Disinterment permits

A. Interred human remains including a fetus which has completed the 20th week of gestation shall not be removed or transported from its place of interment without a disinterment permit. The funeral director or person acting for the funeral director who supervises or is responsible for the disinterment shall apply to the State Registrar for the permit. If the place of initial interment is in a Class A registration district, application shall be made to the local registrar of the registration district.

B. A disinterment permit shall not be required where disinterment and reinterment occurs in the same cemetery for ordinary relocation or for reason of internal management of the cemetery.

C. All disinterment permits shall be valid for 30 days from the date of issue.

D. Except for those disinterments which are ordered by a medical examiner or a court of competent jurisdiction, before a permit for disinterment may be issued, an applicant shall show evidence of having obtained written permission from the decedent's living survivors in the following order of priority:

1. The spouse; or, if unavailable,
2. Children, not minors; or, if unavailable,
3. The father or mother; or, if unavailable,
4. A brother or sister; or, if unavailable,
5. Other relatives.

E. In cases where no known relatives can reasonably be located, an order of the Superior Court of the county wherein the deceased is buried shall serve to authorize the issuance of a disinterment permit.

F. No fee shall be collected for a disinterment permit.

Historical Note

Former Section R9-19-322 renumbered as Section R9-19-328 effective February 20, 1980 (Supp. 80-1). Former Section R9-19-328 renumbered to R9-19-330, new Section R9-19-328 renumbered from Section R9-19-326 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-329. Requirements for preparation and filing of the disinterment permit

The disinterment permit, required by R9-19-328, shall contain the following information:

1. The name, age, sex and race of the deceased; the date and place of death and the location were buried; name of funeral director or person in charge of the disinterment;
2. The signature of the family member or other person granting permission for the disinterment;
3. The signature of the manager of the cemetery or other location from which the remains are removed. If there is no person in charge, the funeral director shall write across this space "no person in charge" and sign his name; and
4. The signature of the manager of the cemetery or other location where the remains are reinterred. If there is no person in charge, the funeral director shall write across this space "no person in charge" and sign his name.

Historical Note

Adopted effective February 20, 1980 (Supp. 80-1). Former Section R9-19-329 renumbered to R9-19-331, new Section R9-19-329 renumbered from Section R9-19-327 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-330. Attachment of disinterment permit while in transit

The disinterment permit shall be placed in a strong, heavy-duty envelope and securely attached to the shipping container in a conspicuous place. A commercial carrier company shall not accept disinterred remains for shipment unless accompanied by a properly completed permit.

Historical Note

Adopted effective February 20, 1980 (Supp. 80-1). Former Section R9-19-330 renumbered to R9-19-332, new Section R9-19-330 renumbered from Section R9-19-328 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-331. Transmittal procedures for a disinterment permit

The disinterment permit shall consist of three copies. The original shall accompany the remains to the place of reinterment or other disposition. The second copy shall be retained by the funeral director and the third copy shall be retained by the issuing registrar. When reinterment is completed, the person in charge of the cemetery or the funeral director shall enter the appropriate endorsement on the original and mail it to the State Registrar within ten days. Local registrars and funeral directors shall retain file copies of disinterment permits for at least two years from the date of issue.

Historical Note

Former Section R9-19-323 renumbered as Section R9-19-331 effective February 20, 1980 (Supp. 80-1). Former Section R9-19-331 renumbered to R9-19-333, new Section R9-19-331 renumbered from Section R9-19-329 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-332. Responsibility for keeping disinterment records

The manager of every regularly organized cemetery shall keep a record of disinterments and reinterments which occur in the cemetery. Such records shall show the name of the deceased, the date and place of death, the cemetery to which removed or the cemetery from which received and the name of the funeral director. Such records shall be subject to inspection by authorized representatives of the State Registrar upon request.

Historical Note

Former Section R9-19-324 renumbered as Section R9-19-332 effective February 20, 1980 (Supp. 80-1). Former Section R9-19-332 renumbered to R9-19-334, new Section R9-19-332 renumbered from Section R9-19-330 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-333. Duties of funeral directors regarding disinterments

A. Disinterments and removal of remains shall be carried out under the guidance or supervision of a funeral director licensed in this state who shall be responsible for the observance and enforcement of all rules pertaining to health and safety. The State Registrar shall permit an exception to the requirement that a funeral director be in charge of the disinterment when the request is made to disinter the remains from a grave of long standing and the State Registrar is satisfied that no hazards to health will be presented.

B. When being removed, disinterred remains shall be deposited in a casket, or other container, so constructed so as to prevent any seepage of fluids or escape of gases or offensive odors. The casket or container shall not be opened for viewing of remains, except in cases involving medical or legal investigations.

Historical Note

Adopted effective February 20, 1980 (Supp. 80-1). Former Section R9-19-333 renumbered to R9-19-335, new Section R9-19-333 renumbered from Section R9-19-331 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-334. Multiple disinterments

Where several graves at one location are to be moved to another location, only one disinterment permit shall be required. However, a list showing the identification of each person insofar as known shall be attached to and made a part of the permit. If the permission of survivors cannot be obtained or if other exigencies outweigh this consideration, the Superior Court of the county wherein the graves are located may issue an order for their removal, which shall be authority to obtain a disinterment permit. In the event the graves lie in more than one county, only one order for removal need be obtained.

Historical Note

Former Section R9-19-326 renumbered and amended as Section R9-19-334 effective February 20, 1980 (Supp. 80-1). Former Section R9-19-334 renumbered to R9-19-336, new Section R9-19-334 renumbered from Section R9-19-332 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-335. Disposition by means of cremation

A. Except as otherwise provided in R9-19-314, no remains shall be cremated except in a facility established solely for the purpose of cremating dead human bodies.

B. A local registrar shall not issue a disposal-transit permit authorizing cremation unless the funeral director has secured and presented the medical examiner's certification as required by A.R.S. § 11-599.

C. A casket shall not be required to cremate human remains.

D. Cremated remains may be disposed of in any manner which does not violate existing federal, tribal, state, county, or municipal laws, rules or ordinances, or the rights of others.

Historical Note

Former Section R9-19-333 adopted effective February 20, 1980 (Supp. 80-1). Renumbered from R9-19-333 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-336. Transportation of cremated human remains

Privately stored cremated human remains may be moved from one place to another within the state without a permit. If the remains are transported outside the state by private conveyance, the State Registrar or local registrar of a Class A registration district may issue a courtesy disposal-transit permit upon request. If the cremated remains are shipped by commercial carrier, they shall be accompanied by a disposal-transit or disinterment permit.

Historical Note

Former Section R9-19-334 renumbered from R9-19-326 and amended effective February 20, 1980 (Supp. 80-1). Renumbered from Section R9-19-334 and amended effective July 31, 1989 (Supp. 89-3).

ARTICLE 4. ACCESS TO RECORDS; COPIES; FEES

R9-19-401. Access to vital records

A. The State Registrar, the Assistant State Registrar and regular employees of the vital records section shall have access to the vital records on file in that office in the conduct of their regularly assigned duties. Other persons shall not be permitted access to the records except under the direct supervision of the State Registrar, Assistant State Registrar, or their designee. Vital records in the custody of a local registrar shall be restricted to those persons whose normal duties require their access to the records or to authorized representatives of the State Registrar.

B. Upon request and proper identification, the State Registrar or the local registrar of a class A registration district may permit an individual who is eligible to receive information in the records to examine a certificate for the purpose of verifying an entry or correcting an error.

Historical Note

Amended effective February 20, 1980 (Supp. 80-1). Amended effective July 31, 1989 (Supp. 89-3).

R9-19-402. Application for copies of vital records

A. Each request for a certified copy of a vital record shall be in writing. The request shall contain the applicant's signature and shall establish the applicant's eligibility to receive a copy of the certificate including the filing of certified copies of documents which establish the appropriate relationship to the registrant. If the registrar determines that the application does not sufficiently establish eligibility, the registrar may require additional documentation from the applicant, including sworn statements. In addition:

1. If applying in person, the applicant shall present valid picture identification issued by a federal, state or local governmental entity which contains the applicant's signature;
2. If applying by mail the request shall be notarized or the applicant shall submit a clear photocopy of a valid identification issued by a federal, state or local governmental agency which contains the applicant's signature.

B. An application shall contain sufficient information about the person or event in question to enable a reasonable search of the files to be made. The State or local registrar may reject any application which is so vague or lacks such information that a reasonable search cannot be made.

C. Telephone orders or verbal requests for copies of vital records or information contained therein shall not be permitted except in extraordinary circumstances and upon authorization of the State Registrar.

Historical Note

Amended effective July 31, 1989 (Supp. 89-3).

R9-19-403. Eligibility for certified copy of birth certificate

A certified copy containing all information on a birth certificate, or a birth certificate for a birth out of wedlock, except the medical and health data section, shall be issued to the registrant, the registrant's authorized agent or upon order of a court of competent jurisdiction,

except that such copy shall not be issued to an unemancipated registrant under 18 years of age without the permission of at least one parent. The "authorized agent" of a registrant shall be:

1. The parents of record of a child;
2. The registrant's spouse or grandparent, an adult child of the registrant, or an adult brother or sister of the registrant who provides proof of relationship to the registrant;
3. A guardian having legal custody or control of a minor child;
4. An attorney representing the registrant, or the registrant's parents if the registrant is a minor, in matters involving the registrant or the registrant's parents;
5. Any person or agency empowered by statute or appointed by a court to act on the registrant's behalf;
6. A federal, state or local governmental agency which requires the copy for official purposes;
7. A governmental agency acting on behalf of the registrant to process a financial claim, benefit, award or other compensation or to transact official business involving the registrant or the registrant's affairs.
8. A family member, or relative of the registrant engaged in research for genealogical purposes who provides proof of relation to the registrant.

Historical Note

Amended effective February 20, 1980 (Supp. 80-1). Amended effective July 31, 1989 (Supp. 89-3).

R9-19-404. Eligibility for certified copy of birth certificate for adoption agencies and private attorneys

A certified copy containing all information on a birth certificate, including a birth certificate for a birth out of wedlock, except the medical and health data section, may be issued to an adoption agency or a private attorney upon submission of certified copies of court records, which establish that:

1. An adoption of the registrant is pending; and
2. The agency or private attorney represents the adoptive parents.

Historical Note

Former Section R9-19-404 repealed, new Section R9-19-404 adopted effective July 31, 1989 (Supp. 89-3).

R9-19-405. Eligibility for certified copy of death certificate

A certified copy of a death certificate may be issued to any applicant with a legal or other vital interest in the record or upon order of a court of competent jurisdiction. An applicant with a "legal or other vital interest" shall include:

1. The surviving spouse or other adult member of the deceased person's immediate family or an attorney, funeral director or other person acting directly for them;
2. A city, county, state or federal governmental agency needing proof of death for official purposes;
3. An insurance company, bank, or hospital with which the deceased maintained business relations and which requires a death certificate for business purposes;
4. An attorney, executor of an estate or individual processing a claim regarding the estate of the deceased in connection with business matters involving the deceased for which the individual can show proof of interest and the need for a copy of the certificate;
5. A family member or relative engaged in research for genealogical purposes who provides proof of relation to the deceased;
6. A government or private agency or individual engaged in research for medical or scientific purposes; or
7. Any other applicant who provides a signed authorization to release the copy to the applicant from the surviving spouse or other adult member of the deceased's immediate family.

Historical Note

Amended effective July 31, 1989 (Supp. 89-3).

R9-19-406. Eligibility for certified copy of fetal death certificate

A certified copy of a fetal death certificate may be issued to the parents of a fetus or to another person upon authorization from a parent.

Historical Note

Amended effective July 31, 1989 (Supp. 89-3).

R9-19-407. Authority to issue certified copies; certifications of birth

A. Only the State Registrar and the county registrar of a Class A registration district shall issue certified copies of a vital record, or computer-generated certifications of birth. Certified copies may be issued only when the registrar has the original certificates in his custody. Computer-generated certifications of birth, issued by a Class A registration district, shall be issued from the data file maintained by the State Registrar and in accordance with the following:

1. Copies shall be issued only to residents of the Class A registration district.
2. Copies shall be issued only upon paper authorized by the State Registrar.
3. A fee of five dollars shall be collected for each computer-generated certification issued. The fee shall be deposited with the county treasurer.
4. An amount equal to one-third of the revenue collected from the issuance of computer-generated certifications of birth by Class A registration districts shall be sent to the State Registrar by the 15th day of the month following collection to support the state's cost of maintaining the computerized record search system.

B. Local registrars of all other registration districts shall not issue copies, certified or otherwise. Local registrars may receive or retain duplicate copies of forms for their administrative use but shall not release information from the forms to the public or to any individual except with permission of the State Registrar. Authorized representatives of the State Registrar may have access to the files in the conduct of official duties.

Historical Note

Amended effective June 15, 1984 (Supp. 84-3). Amended Subsection A. Paragraph 2. effective August 31, 1988 (Supp. 88-3). Amended effective July 31, 1989 (Supp. 89-3).

R9-19-408. Standards for copies

A. No certified copy which is a reproduction of a vital record form shall be valid unless it:

1. Contains an appropriate certification statement over the signature of the registrar having custody of the record and is impressed with the raised seal of the issuing office. The signature may be photographed or entered by mechanical means.
2. Is prepared by photographic or dry copy reproduction process. If prepared by standard photographic process, the copy shall not be smaller than one-half the size of the original and shall be printed only upon paper approved by the State Registrar. If prepared by dry copy process, heavy grade safety paper or specially treated paper

approved by the State Registrar shall be used. The paper shall display the official seal of the issuing agency, its parent political jurisdiction or the seal of the state. The seal shall be entered either by standard printing process or by watermark.

B. The Office of Vital Records shall provide for reasonable safeguards against forgery, unauthorized reproduction or misuse of vital record forms.

Historical Note
Amended effective July 31, 1989 (Supp. 89-3).

R9-19-409. General conditions for release of information from vital records for research and other uses

A. A copy of all or part of a vital record or information derived therefrom, including birth certificates for births out of wedlock, may be released to government agencies, hospitals, foundations, schools, social agencies and similar organizations or individuals for scientifically or medically-related statistical or research purposes. All such requests shall clearly identify the requesting agency or individual, state the number of copies needed, explain the objective of the study and contain a statement over the applicant's signature expressing familiarity with the confidentiality aspects of the records and his willingness to abide by all restrictions.

B. The researcher shall not:
1. Disclose the name or address of any individual identified or any other personally identifiable information on a certificate in published results of the study or in communication with others;
2. Contact any individuals named on a certificate without prior permission from the State Registrar;
3. Deliver the information to other persons not connected with the study; or
4. Use the information in any way so as to violate the privacy of any individual named on a certificate or cause embarrassment to the registrant or the registrant's family.

C. Violations may cause the Department to bar the applicant from obtaining further assistance in issues relating to research of vital records. The applicant may also be subject to such other legal action as may be appropriate.

Historical Note
Amended effective February 20, 1980 (Supp. 80-1).
Former Section R9-19-409 repealed, new Section R9-19-409 renumbered from Section R9-19-410 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-410. Release of information to governmental agencies

When certified copies are not needed, certain facts on birth and death certificates may be furnished without charge to federal, state, county or municipal agencies for use in the conduct of their official duties. The State Registrar shall prescribe the forms to be used, manner of furnishing the information, assurances of confidentiality and other administrative arrangements. This work shall be secondary to other demands upon the Department. Where a request is of a continuing nature which extends over a long period of time or the number of requests from an agency is substantial, the State Registrar may require the requesting agency to furnish forms and pay all postage charges.

Historical Note
Amended effective February 20, 1980 (Supp. 80-1).
Former Section R9-19-410 renumbered to R9-19-409, new Section R9-19-410 renumbered from Section R9-19-411 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-411. Identification of persons shown on vital records; prohibition

Information from vital records identifying persons by name or address or through any other personally identifiable information shall not be released except as provided by these rules. Under no circumstances shall such information be given to any organization or individual in order to solicit sale of a product, offer any service for compensation, locate persons named on the certificate, distribute partisan literature, use for political purposes or for any similar commercial use where the privacy of the individual would be compromised or invaded. The State Registrar is authorized to require a sworn statement of purpose in all such instances where it appears the information may be misused.

Historical Note
Former Section R9-19-411 renumbered to R9-19-410, new Section R9-19-411 renumbered from R9-19-412 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-412. Payment of fees

All fees shall be paid at the time of application for the records. Fees shall be paid before certified copies are delivered to the applicant. If fees are paid in other than cash, certified check or money order, sufficient time for personal checks to clear shall be allowed to elapse prior to delivering copies to the applicant.

Historical Note
Former Section R9-19-412 renumbered to R9-19-411, new Section R9-19-412 renumbered from Section R9-19-413 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-413. Fee Schedule

A. In the following an applicant shall be charged:
1. $8 for each certified copy of a birth certificate, or "certificate of no record" if the certificate is not on file.
2. $5 for each certified copy of a death certificate, or a "certificate of no record" if the certificate is not on file.
3. $5 for each computer-generated birth certification.
4. $8 for each certified copy of an Affidavit of Acknowledgment of Paternity.
5. $3 for each of the first 10 years searched and $2 for each additional record year searched when the registrant's name, the date and place of birth or death, or other identifying information is not known. The search fee does not include the issuance of a certified copy if the certificate is found.
6. $13 as an application fee to file a delayed certificate of birth, death, or fetal death. The applicant shall receive 1 certified copy of the complete record without additional charge.
7. $13 to establish a new birth certificate following adoption, legitimation, paternity determination, or surgical alteration or to create a death certificate based on a court finding of death. The applicant shall receive 1 certified copy of the new certificate without additional charge.
8. $13 as an application fee to add an amendment or supplement to any certificate showing judicial changes or major administrative changes which occur 90 days or more after date of the event. The applicant shall receive 1 copy of the amended certificate without additional charge.
9. $13 as an application fee to add missing or omitted information or minor administrative changes 1 year or more after the date of the event. The applicant shall receive 1 certified copy of the amended certificate without additional charge.

10. $2 per copy of each noncertified copy issued or for each search to verify birth or death data for statistical, medical, research, or administrative purposes.
11. $3 for postage and handling of refunds.
12. The fee and method of payment determined by the State Registrar for scientific, medical, statistical, or research services based upon the costs of computer time, manpower, postage, and material.
13. Ten dollars for each search for a putative father in the putative fathers registry.

B. No fee shall be charged physicians, hospitals, medical examiners or funeral directors who submit information at any time to correct errors or otherwise add to the completion of a certificate.

Historical Note

Amended effective February 20, 1980 (Supp. 80-1). Former Section R9-19-414 repealed, new Section R9-19-414 adopted effective June 15, 1984 (Supp. 84-3). Amended Subsection (A) effective August 31, 1988 (Supp. 88-3). Former Section R9-19-413 renumbered to R9-19-412, new Section R9-19-413 renumbered from Section R9-19-414 and amended effective July 31, 1989 (Supp. 89-3). Amended effective February 12, 1996 (Supp. 96-1).

R9-19-414. Services without charge

A. Pursuant to the provisions of A.R.S. § 39-122(A), there shall be no charge for a search of the files or for a certified copy of a vital record to be used in any claim against the U.S. Government for financial compensation for the following:
1. Social Security or similar retirement benefits;
2. Allotments to dependents of military personnel on active service;
3. Pensions to veterans of the armed forces or their survivors;
4. Payments of U.S. Government or NSLI life insurance proceeds; or
5. Any other claim which in the opinion of the State Registrar meets the general requirements of the statute.

B. The registrar may issue a certified copy without charge to any federal, state or local government agency when it can be determined that the record is to be used primarily for the benefit of the government agency in the transaction of official business.

Historical Note

Former Section R9-19-414 renumbered to R9-19-413, new Section R9-19-414 renumbered from Section R9-19-415 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-415. Accounting of collected fees

All fees collected by the State Registrar or a local registrar shall be handled in accordance with the provisions of A.R.S. § 36-342 and other applicable laws.

Historical Note

Former Section R9-19-415 renumbered to R9-19-414, new Section R9-19-415 renumbered from Section R9-19-416 and amended effective July 31, 1989 (Supp. 89-3).

R9-19-416. Renumbered

Historical Note

Former Section R9-19-416 renumbered to R9-19-415 effective July 31, 1989 (Supp. 89-3).

TITLE 9. HEALTH SERVICES

CHAPTER 20. DEPARTMENT OF HEALTH SERVICES BEHAVIORAL HEALTH SERVICE AGENCIES: LICENSURE

New Title 9, Chapter 20 was adopted and amended by the Department of Health Services pursuant to an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Laws 1992, Ch. 301, § 61). Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is being printed on blue paper.

Former Title 9, Chapter 20 renumbered and repealed as follows: Article 1 renumbered to Title 18, Chapter 7, Article 1; Article 2, consisting of Sections R9-20-201 through R9-20-226, repealed effective September 27, 1989 (Supp. 89-3); Article 3 was reserved; Article 4 renumbered to Title 18, Chapter 9, Article 7; and Article 5 renumbered to Title 18, Chapter 4, Article 1.

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ARTICLE 1. GENERAL

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-101. Definitions

A. Words and phrases defined in A.R.S. §§ 36-401, 36-501, 36-2021, and 36-3001 have the same meaning when used in this Article. In this Article, unless the context otherwise requires:

1. "Abuse" means, with respect to a client, the infliction of, or allowing another person to inflict or cause, physical pain or injury, wrongful confinement, impairment of bodily function, disfigurement or serious emotional damage as evidenced by severe anxiety, depression, withdrawal or aggressive behavior. Emotional damage must be diagnosed by a medical doctor or psychologist. Such abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a client receiving behavioral health services under this Chapter. Abuse shall also include sexual misconduct, assault, molestation, incest, or prostitution of, or with, a client under the care of personnel of a licensed behavioral health service agency or a mental health agency.
2. "Accreditation" means formal recognition issued by a nationally recognized organization to indicate that an agency or provider is providing behavior health services in accordance with the national standards of the accreditation agency.
3. "Administrator" means a licensee or staff member who is authorized in writing by the governing authority of a licensed behavioral health service agency to conduct the agency's business and daily operation and carry out administrative functions specified by the agency's governing authority pursuant to this Article.
4. "Architectural review" means the examination by the Department of any specifications submitted by an applicant.
5. "Assessment" means the analysis of a person's medical, psychological, psychiatric, or social conditions to determine if an agency's direction of care is suitable to the person's problematic behavioral health issue(s). An assessment is an integral part of the agency's admission process and may be conducted on an inpatient basis, an outpatient basis, or a combination of both. Assessment may include screening, evaluation, and diagnosis.
6. "Basic partial care services" means treatment services provided in a structured, coordinated program or by goal-oriented services designed to provide therapeutic activities. Services may include those which promote coping, problem-solving and socialization skills and provide regular activities for clients requiring supportive counseling such as psychosocial rehabilitation, life skills training, independent living skills, and medication training.
7. "Begin construction" means to initiate action at the project site, implement the construction documents, or to initiate work orders.
8. "Behavioral health issue" means a mental health disorder, personality disorder, emotional condition or alcohol, drug or other substance abuse problem that may be improved or eliminated through behavioral health services provided to the affected client by personnel of a licensed behavioral health service agency.
9. "Behavioral health paraprofessional" means a staff member of a licensed behavioral health service agency who meets qualification requirements specified in R9-20-306(D).
10. "Behavioral health professional" means a psychiatrist, psychologist, social worker, counselor, nurse practitioner, physician assistant, or registered nurse who meets the qualification specified in R9-20-306(B).
11. "Behavioral health residential services" means a live-in program consisting of a therapeutic regimen of screening, evaluation, treatment or rehabilitation provided on a 24-hour basis in a supervised environment to clients suffering from mental disorders, personality disorders, emotional conditions or the effects of substance abuse.
12. "Behavioral health service" means assessment, screening, evaluation, diagnosis, care or treatment to maintain progress toward normal functioning, reduce or eliminate mental health or personality disorders, emotional conditions and/or substance abuse.
13. "Behavioral health service agency" or "agency" means a class of health care institution that provides one or more behavioral health services on a voluntary or court-ordered basis.
14. "Behavioral health technician" means a staff member of a licensed behavioral health service agency who meets qualifications specified in R9-20-306(C).
15. "Behavior management services" means services that primarily involve direct patient behavior management but may also include services related to activities of daily living and household activities incidental to, and consistent with, the mental health rehabilitative needs of the client.
16. "Case management team" means a team of professionals who are responsible for providing continuous treatment and support to adults and children with serious mental illnesses and for locating, accessing, and monitoring the provision of behavioral health services.
17. "Case manager" means an individual meeting the requirements of R9-20-306(F), who participates in the development of client specific behavioral health treatment services; is responsible for developing the most cost-effective, medically appropriate, individual service plan; and who arranges for and monitors service provision for clients.
18. "Child" means a person who is under the age of 18 years.
19. "Client" means an individual receiving direct behavioral health services from the staff of a licensed behavioral health service agency. A client may be termed a patient, resident or ward.
20. "Client record" means the written compilation of information that describes and documents the evaluation, diagnosis or treatment of a client.
21. "Community services" means community behavioral health services required to be provided under A.R.S. § 36-550 et seq. and includes, but is not limited to, clinical case management, outreach, housing and residential services, crisis intervention and resolution services, mobile crisis teams, day treatment, intensive in-home counseling, behavior management, basic partial care, vocational training and opportunities, habilitation or rehabilitation services, psychosocial rehabilitation, peer support, social support, recreation services, advocacy, family support services, outpatient counseling and treatment, transportation, and medication evaluation and maintenance.

22. "Counseling" means a method of treatment provided by staff who meet the requirements pursuant to R9-20-306 of a licensed behavioral health service agency that utilizes the interaction between the staff member and a client, or clients, to improve or alleviate one or more behavioral health issues.
23. "Counselor" means a marriage and family counselor, behavioral health counselor, or substance abuse counselor who meets the requirements as a behavioral health professional pursuant to R9-20-306(B).
24. "Court-ordered alcoholism treatment services" means involuntary detoxification or residential services that are provided, in a behavioral health service agency licensed for such services, to clients designated as chronic alcoholics pursuant to A.R.S. Title 36, Chapter 18.
25. "Court-ordered mental health evaluation" means the assessment of a person's medical, psychological, psychiatric, or social condition to determine whether the person has a mental or personality disorder and is a danger to self or others, is acutely and persistently disabled, or is gravely disabled as defined in A.R.S. Title 36, Chapter 5.
26. "Court-ordered mental health evaluation agency" means facility licensed by the Department to provide court-ordered mental health evaluations in accordance with A.R.S. Title 36, Chapter 5.
27. "Court-ordered mental health evaluation and diagnosis" means assessment of a person's medical, psychiatric, psychological, or social conditions to determine if a mental disorder exists and, if so, to provide diagnosis for direction of care.
28. "Court-ordered mental health treatment services" means treatment services provided pursuant to A.R.S. Title 36, Chapter 5, as determined necessary by the court-ordered mental health evaluation and required by the Superior Court.
29. "Crisis services" or "emergency services" means the same as emergency/crisis behavioral health services.
30. "Crisis stabilization facility" means a facility which provides 24-hour supervision of clients who require a protected supervised environment to reduce or eliminate an emergency situation, and licensed pursuant to Articles 6 or 7.
31. "Deemed status" means the acceptance by the Department of a copy of the institution's current accreditation report from a nationally recognized accreditation organization in accordance with A.R.S. § 36-401(A)(1) and in lieu of licensing inspections required by this Chapter.
32. "Department" means the Arizona state Department of Health Services.
33. "Designated representative" means the person or persons designated by a client or guardian to assist the client in protecting the client's rights.
34. "Detoxification" means the treatment services provided to systematically reduce physical dependence upon alcohol, drugs or other substances by use of therapeutic procedures, e.g., medications, rest, diet, counseling or medical supervision.
35. "*Diagnostic and Statistical Manual of Mental Disorders*" or "DSM" means the latest edition of the manual that is edited by the American Psychiatric Association.
36. "Director" means the Director of the Department of Health Services.
37. "Discharge" means the termination of the client's affiliation with a licensed behavioral health service agency and the cessation of behavioral health services provided to that client.
38. "Emergency/crisis behavioral health services" means immediate and intensive, time-limited, community-based, face-to-face crisis intervention and resolution services which are available on a 24-hour-a-day basis. Services may include evaluation and counseling to stabilize the situation, mobile crisis services, emergency crisis shelter services, and crisis management counseling, psychotropic medication stabilization, and/or other therapeutic activities to reduce or eliminate the emergency situation.
39. "Goal" means an expected result or outcome to improve or eliminate a problematic condition, which takes time to achieve, is specified in a statement of relatively broad scope in a treatment plan, and provides guidance in establishing intermediate objectives directed toward its attainment.
40. "Grievance" means a complaint regarding an act, omission, condition, or decision.
41. "Group therapy" means a method of treatment that uses the interaction between a psychiatrist, psychologist, behavioral health professional, or behavioral health technician and two or more clients to promote improvement or change of behavioral health issues.
42. "Guardian" means an individual appointed by court order pursuant to A.R.S. Title 14, Chapter 5 or Title 36, Chapter 5, or similar proceedings in another state or jurisdiction properly domesticated under Arizona law. Guardian may also refer to an agency, designated by state law, which is responsible for some degree of care or management.
43. "Halfway house" means a behavioral health service agency that provides a residential setting that aids a client in the transition from a more restrictive setting to independent living.
44. "Halfway house services" means services provided in a halfway house that provide clients the opportunity to function as part of a household, develop independence in daily living and be involved in activities during the day, including vocational and educational opportunities and community activities.
45. "Human subject" means any individual living or dead about whom an investigator (whether professional or student) conducting research obtains data through intervention or interaction with the individual, or obtains identifiable private information.
46. "Individualized treatment plan" or "ITP" means a written plan for client care to meet the client's needs identified through the assessment, evaluation, and diagnosis processes.
47. "Intensive partial care services" means treatment services provided that are planned, structured, and coordinated therapeutic activities including a program of services which address the client's therapeutic goals as outlined in the client's individual treatment plan. These services provide a structured, coordinated program of intensive care which is scheduled on a regular basis, providing active treatment intended to lead to full or partial resolution of the client's acute or episodic problems. Services may include a variety of treatment modalities such as individual, group and family therapy, cognitive and psychodynamic approaches to the client's problems, and treatment-related activities intended to reduce the need for more intensive services.
48. "Level I behavioral health facility" means a behavioral health service agency that provides a structured treatment

setting with daily 24-hour supervision and an intensive treatment program.

49. "Level II behavioral health facility" means a behavioral health service agency that provides a structured residential treatment setting with 24-hour supervision and counseling or other therapeutic activities for clients who do not require on-site medical services.
50. "Level III behavioral health facility" means a behavioral health service agency that provides a residential setting with 24-hour supervision for clients who are determined to be capable of independent functioning but still require protective oversight to insure they receive needed medications and transportation and are provided with needed therapeutic services outside the facility.
51. "License" means a certificate issued by the Department that indicates that the behavioral health service agency has been determined to be in substantial compliance with applicable state requirements and is authorized by the Department to provide one or more specified behavioral health services.
52. "Likelihood of serious physical harm" means:
    a. A substantial and imminent risk that serious physical harm will be inflicted by an individual upon himself, as evidenced by threats or attempts to commit suicide or to inflict physical harm on himself; or
    b. A substantial and imminent risk that serious physical harm will be inflicted by an individual upon another as evidenced by previous behavior that has caused such harm or that places another person or persons in fear of sustaining such harm. Substantial and imminent risk shall be interpreted to include only those instances where there is the present ability to enact serious physical harm or where there is a realistic perception of such ability.
53. "Manufactured housing" means a structure built in accordance with the National Manufactured Home Construction and Safety Act of 1974 and Title 6 of the Housing and Community Development Act of 1974, Public Law 93-383, as amended by Public Laws 95-128, 95-557, 96-153, and 96-339.
54. "Mechanical restraint" means the use of any article, device, or garment that restricts a client's freedom of movement or a portion of a client's body and cannot be removed by the client, and that is used for the purpose of confining the client's mobility, but does not include such a device used for orthopedic, surgical or other medical device necessary to allow a client to heal from a medical condition or to participate in a treatment program.
55. "Medical emergency" means a situation that involves a threat of death or serious physical harm to a behavioral health client and requires immediate medical intervention.
56. "Medication" means any prescription drug as ordered by the client's physician of record and provided for use by a client.
57. "Medication monitoring administration and adjustment" means review of laboratory test results, observation of client behaviors, recording client reaction to medications, and adjustment of medications to alter negative reactions or to obtain desired therapeutic levels.
58. "Menu" means a written description of foods to be served at each meal and all snacks catered for, or prepared at, a licensed behavioral health service agency.
59. "Mobile crisis unit" means one or more individuals who provide emergency/crisis behavioral health services under the authority of a licensed behavioral health service agency. At least one member of the unit shall be a behavioral health professional pursuant to R9-20-306(B).
60. "Nurse" means a person who is licensed under A.R.S. Title 32, Chapter 15.
61. "Nurse practitioner" means a person who is licensed under A.R.S. Title 32, Chapter 15 and certified by a national nursing credentialing agency that is recognized by the Arizona Board of Nursing.
62. "OBHL" means the Office of Behavioral Health Licensure.
63. "Objective" means an expected result or outcome which is stated in measurable terms, has a specified time for achievement, and is related to attainment of a goal.
64. "Outpatient rehabilitation services" means a therapeutic regimen of services, provided by a licensed behavioral health service agency in an ambulatory setting during specified hours of operation, including case management, screening, assessment, evaluation, treatment planning, treatment, counseling and/or other therapeutic activities for clients with behavioral health issues.
65. "Personnel" means all staff including full- or part-time employees and volunteers, who perform services for clients of a licensed behavioral health service agency.
66. "Physical restraint" means the use of bodily force to restrict the person's freedom of movement but does not include the firm but gentle holding of a person with no more force than necessary to protect the person or others from harm. SMI clients must not be held for more than five minutes.
67. "Physician assistant" means a person who is licensed under A.R.S. Title 32, Chapter 25.
68. "Policy" means a statement of the principles that guide and govern the activities, procedures and operations of a licensed behavioral health service agency.
69. "Pre-petition mental health screening" means, upon receiving an application for court-ordered evaluation, the screening agency shall determine whether:
    a. Reasonable cause exists regarding applicant allegations for the court-ordered evaluation.
    b. The person will voluntarily receive evaluation at a scheduled time and place.
    c. The person is gravely disabled or likely to present a danger to self or others until the voluntary evaluation, or
    d. The person is persistently or acutely disabled.
70. "Pre-petition mental health screening agency" means a facility licensed by the Department to provide pre-petition screening pursuant to A.R.S. Title 36, Chapter 5.
71. "PRN order" or "Pro re nata medication" means medication given as needed.
72. "Procedures" means the designated methods by which policies are put into effect and agency operations are to be carried out.
73. "Program" means an organized system of services designed to address the treatment needs of clients.
74. "Program director" means the person with the day-to-day responsibility for the operation of a programmatic component of a service provider, such as a specific residential, vocational, or case management program.
75. "Psychiatric acute care" means emergency/crisis behavioral health services, psychiatric and psychological evaluation, short-term intensive behavioral health counseling and treatment for acute episodes of mental disorders, medication stabilization and 24-hour nursing care for clients with acute psychiatric or mental disorders, or who need to stabilize chronic mental illness.

76. "Psychiatrist" means a physician licensed in Arizona under A.R.S. Title 32, Chapter 13 or 17 and Board certified or Board eligible under the standards of the American Board of Psychiatry and Neurology or the Osteopathic Board of Neurology and Psychiatry.
77. "Psychologist" means a professional who is licensed under A.R.S. Title 32, Chapter 19.1 and is experienced in the practice of psychology.
78. "Psychosocial rehabilitation" services means a comprehensive program of active treatment which may include activities of community and daily living, training in communication, and medication.
79. "Psychotherapy" means a method of treatment for mental disorders and substance abuse which uses the interaction between a therapist and a client to promote emotional or psychological change or to alleviate a mental disorder or substance abuse. Psychotherapy must be rendered by a psychiatrist, psychologist, or behavioral health professional.
80. "Qualified clinician" means a behavioral health professional licensed or certified under A.R.S. Title 32, or a behavioral health technician or case manager supervised by a behavioral health professional licensed or certified under A.R.S. Title 32 or credentialed by the Arizona Board for the Certification of Addiction Counselors or credentialed by a national organization recognized by the Department as having standards equal to or exceeding those specified for certification under A.R.S. Title 32.
81. "Referral" means assistance or direction to a person or the person's family, guardian or designated representative to obtain information and locate medical, legal, psychological, social, educational, vocational or other services needed for the reduction or management of behavioral health issues.
82. "Restraint" means any restraining device that is designed and applied for the purposes of preventing the individual from engaging in assaultive or self-abusive behavior or to prevent serious disruption of the therapeutic environment. Restraint includes physical activities, mechanical devices and pharmacological use.
83. "Restrictive behavior management" means the use of medication, mechanical restraints, or seclusion for a client suffering a behavioral health emergency when less restrictive measures to assist the client in regaining control have failed.
84. "Satellite office" means an off-site office used periodically but less than 20 hours per week by an outpatient clinic, outpatient rehabilitation agency or an outpatient program offered by a hospital licensed pursuant to A.A.C. Title 9, Chapter 10, Articles 2, 3, or 4.
85. "Seclusion" means placing a client alone in a room with closed, locked doors that cannot be opened from the inside, for the purposes of preventing the client from engaging in assaultive or self-abusive behavior or to prevent serious disruption of the therapeutic environment for SMI clients as defined in R9-21-101.
86. "Secured residential facility" means a Level I facility providing restrictive behavioral health management services.
87. "Seriously mentally ill" or "SMI" means a person 18 years of age or older who is chronically mentally ill as defined in A.R.S. § 36-550.
88. "Shelter resident" means a person who is receiving shelter services from a licensed behavioral health service agency authorized to provide shelter services.
89. "Shelter Services" means shelter care, crisis intervention, the arrangement of short-term counseling, and planning for aftercare and other services to resolve the emergency and protect or prevent harm to a shelter resident or an individual seeking shelter services.
90. "SMI clinical case management services" means the screening, evaluation, diagnosis, crisis management, therapy, and medication adjustment and monitoring.
91. "SMI clinical case management team" consists of a psychiatrist, case manager, and other behavioral health professionals responsible for case management, individual service plan development and treatment, identification of service providers, and authorization of services.
92. "Social worker" means a person who has received a degree in social work from an accredited school of social work and has clinical experience in the needs of clients admitted to licensed behavioral health service agencies or who has been certified as a social worker by the Board of Behavioral Health Examiners pursuant to A.R.S. Title 32, Chapter 33.
93. "Special hospital" or "Special hospital, psychiatric" means a subclass of hospital that specializes in providing, by or under the supervision of a psychiatrist or other physician, psychiatric or behavioral health services for the diagnosis and treatment of persons with behavioral health issues and which is licensed by the Department to provide behavioral health services.
94. "Special unit" means a unit or ward within a general hospital that is primarily engaged in providing, by or under the supervision of a psychiatrist or other physician, psychiatric or behavioral health services for the diagnosis and treatment of persons with behavioral health issues and which is licensed by the Department to provide behavioral health services.
95. "Specifications" means a detailed and exact statement of particulars describing materials, dimensions, and workmanship of something to be built, installed, or manufactured.
96. "Staff" means full- or part-time employees who are paid by a licensed behavioral health service agency to perform assigned job functions for that agency.
97. "Substance abuse" means the chronic, habitual or compulsive use of any chemical matter that, when introduced into the body in any way, is capable of causing altered human behavior or altered mental functioning and which, if used over an extended period of time, may cause psychological or physiological dependence or impairment and reduction or destruction of social and/or economic functioning.
98. "Substantial modification" means:
    a. Increased bed capacity or the change in the use of one or more existing beds; or
    b. A change in the address or location at which a service is provided; or
    c. A change in the physical plant of the institution that affects compliance with any applicable code or standard as referenced in A.A.C. R9-1-412, or in the physical plant standards in A.A.C. Title 9, Chapter 10; or
    d. A change from one licensed behavioral health service category to another, e.g., Level II residential facility changed to Level I residential facility.
99. "Therapeutic activity" means a planned activity or service that is specified in a client's treatment plan as a component of a client's treatment.
100. "Treatment" means the range of planned behavioral health services received by a client, which is consistent with the assessment of the client, the client's evaluation

and diagnosis and individual treatment plan goals and objectives, in order to manage, improve or eliminate behavioral health issues. Such services may include psychiatric or psychological testing, counseling, medical care, training, psychosocial rehabilitation, habilitation, recreation, rehabilitation and social services.

101. "Volunteer" means a person who, without direct financial remuneration, provides services to a licensed behavioral health agency.
102. "Working days" means Monday, Tuesday, Wednesday, Thursday and Friday, excluding holidays.

B. In the event the definitions in A.A.C. Title 9, Chapter 21 differ from the definitions in this Chapter, the more restrictive definition applies.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency errors corrected to definitions 18, 47, 61-64, and 67 pursuant to letter received in the Office of the Secretary of State October 8, 1993 (Supp. 93-4).

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R9-20-102. Licensure Requirements; Exceptions

A. No public or private corporation, association, or other organization, whether for profit or not, shall establish, maintain or operate an agency, institution, or part thereof, that provides behavioral health services for the care and treatment of persons with behavioral health issues without first securing a license in accordance with this Chapter.

B. Licensed general hospitals shall apply for behavioral health service agency licensure in order to provide one or more behavioral health services. If the licensed general hospital is in full compliance with A.A.C. Title 9, Chapter 10, Articles 1 and 2, the general hospital shall be exempt from inspection for compliance with R9-20-408, R9-20-502, and R9-20-503.

C. Special hospitals licensed pursuant to A.A.C. Title 9, Chapter 10, Article 4 shall apply for a behavioral health service agency license pursuant to this Chapter. If the special hospital is in full compliance of A.A.C. Title 9, Chapter 10, Articles 1 and 4, the special hospital shall be exempt from inspection for compliance with R9-20-408, R9-20-502, and R9-20-503.

D. In addition to applicable Articles in this Chapter, all behavioral health service agencies licensed pursuant to this Chapter and providing services to SMI clients shall comply with A.A.C. Title 9, Chapter 21.

E. In addition to applicable Articles in this Chapter, all behavioral health service agencies licensed pursuant to this Chapter and providing Title XIX-certified services shall be subject to A.A.C. Title 9, Chapter 22.

F. These rules shall not apply to:

1. Agencies that provide only administrative services to operate and provide behavioral health services but do not provide direct patient evaluation, diagnosis, case management, care or treatment.
2. Educational services or activities offered under the authority of an educational institution accredited by a nationally recognized accreditation organization.
3. Telephone hot-line programs that do not provide face-to-face, on-site behavioral health services.
4. Member-run self-help or self-growth groups.
5. Private offices and clinics of private practitioners who are licensed or certified under A.R.S. Title 32 but are not responsible to a Board of Directors and do not employ or contract with others to deliver behavioral health services.
6. Agencies and foster care facilities licensed by the Department of Economic Security (DES) pursuant to A.R.S.§§ 8-503, 36-558.01 and 36-591 and which do not provide behavioral health services.
7. Exemptions as stated in A.R.S. § 36-402.

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R9-20-103. Licensure Procedure

A. An application for a behavioral health service agency shall be submitted on forms issued by the Department prior to an agency seeking initial licensure or a substantial modification change in services provided to clients. Pursuant to A.R.S. § 36-421, a permit shall be required for the construction of a health care institution, initial licensure of a health care institution, or substantial modification of a health care institution, its facilities, or services.

1. Where more than one class or subclass of health care institutions occupy the same physical plant and is operated by the same governing authority, two permit applications shall be required for a modification or change in services in a specific area that is being transferred from one licensed institution to another.
2. The applicant shall submit a nonrefundable fee of $25 with the permit application; however, health care institutions owned and operated by the state are exempt from fees.

B. Permit application. The application shall contain specific supporting documentation including, but not limited, to the following:

1. A copy of local zoning approval and/or use permits;
2. A copy of the Certificate of Occupancy, if applicable;
3. A copy of a fire inspection issued within the past 12 months. This time period shall be extended if the local fire inspection is required less frequently;
4. A copy of the business license, if applicable;
5. A revenue and expense statement for the project described in the permit;
6. Anticipated project costs along with a Source of Funds Statement;
7. Number and type of staff required for the project; and

8. A detailed description of all services to be offered and how the services provided meet the minimum standards for licensure within the class or subclass of health care institution for which it is intended.

C. Where local jurisdictions do not provide specific documents required in subsection (B), the applicant shall obtain from the local jurisdiction a letter stating that they do not provide the documents listed.

D. In addition to subsections (B) and (C), the applicant shall submit specifications for architectural, structural, mechanical, plumbing and fire protection systems as follows:
1. Specifications for each area which shows the relationship of the various services to each other and their arrangements;
2. Estimated date of completion of project shall be included and, if phased construction is contemplated, the completion date of each phase of the project;
3. Drawings of sprinkler, fire alarm, smoke detector, and chemical extinguishing systems shall show evidence of approval by the local fire protection agency; and
4. Final construction documents submitted to the Department shall be certified pursuant to A.R.S. Title 32, Chapter 1.

E. The Department shall notify the applicant of any deficiencies in required information from subsections (B), (C) and (D). The Department shall establish a time schedule for the submission of required information.

F. Permit issuance.
1. The Director shall issue the permit within 60 days when all required documentation has been submitted, reviewed and approved.
2. If required documentation is not submitted within 15 calendar days, or written justification thereof, the Director shall deny the application.
   a. Pursuant to A.R.S. § 36-428, if the application is denied, the applicant shall be given written notification of denial and may request a hearing, in writing, before the Director within 30 days after the receipt of the notice.
   b. The applicant shall submit a new permit application and appropriate fees if they intend to initiate a project that has been denied.

G. A permit shall be valid for a period of 120 days from its date of issuance or the estimated project completion date which ever is longer.

H. The Director may grant up to three extensions if the applicant is unable to begin construction or be licensed for the new service within 120 days after the issuance of a permit. Three extensions may be granted for projects that have begun but exceed the estimated project completion date. The request for extension shall be in writing and contain the reason for the permit holders' inability to begin construction or licensing the new service due to causes beyond the applicant's control and that there was no contributory fault or negligence on the applicant's part. The request for extension shall be submitted 30 days prior to the expiration date of the permit. Each extension shall not exceed 120 days. If the permit holder desires to make deviations from the approved specifications, the Department shall be notified and the owner may not proceed with the change until a revised permit is approved by the Director.

I. The permit holder shall implement each project in conformance with the project description, schedule and other conditions of the permit in the following manner:
1. Construction may begin immediately upon, but not prior to, the receipt of the permit.
   a. All construction shall be completed on or before the completion deadline specified in the permit unless a written extension is granted by the Director.
   b. A copy of the permit shall be kept with other construction documents at the construction site.
2. Systems planning for service delivery may begin upon receipt of the permit; service delivery may begin immediately upon, but not prior to, the receipt of the license certificate. A copy of the permit shall be kept with other related documents at the service delivery site.

J. A copy of the Certificate of Occupancy issued by the appropriate local authority or other satisfactory evidence of project completion shall be filed with the Department within 60 days after completion of the project. Failure to submit required post-project documents shall result in grounds for denial of future permit applications.

K. Newly constructed, or modified areas, shall not be used for client activities until the applicant has received written authorization from the Department stating that the area is approved for patient use. This written authorization shall not be the permit as described in this Article. If further review is considered necessary or desirable to verify the accuracy of the information submitted pursuant to this Article, the Department may further examine records and accounts related to the reporting requirements of this Article.

L. Licensure application
1. An applicant for behavioral health licensure shall submit an application to the Department on forms provided by the Department. The applicant shall provide the following information:
   a. The initial, including addition/deletion of services and change in address, or renewal category of license the applicant is seeking;
   b. Organizational identification:
      i. The name of the owner of corporation with the complete mailing address, phone and fax numbers;
      ii. The name in which the facility is doing business with the address, phone and fax numbers;
   c. Management data which indicates:
      i. The name of the chief executive officer or the persons who are responsible for the administration of the institution; and
      ii. The name of the chief administrative officer who is responsible for the implementation of policies and procedures at the facility site;
   d. Scope of services which indicates each type of service for which the facility is seeking licensure;
   e. Program services which describe facility accreditation, regional behavioral health authority affiliation, and any co-licensure status, if applicable, and population to be served;
   f. Physical plant accommodations for residential facilities;
   g. Staffing pattern and qualifications for employees, contract/consultant personnel, and volunteers who provide both indirect and direct behavioral health services;
   h. A list of all employees, contract/consultant personnel and volunteers who provide direct services to clients under the age of 18;
   i. A list of satellite or off-campus offices outpatient facility sites which provide services less than 20 hours per week;
   j. Attachments, including facility program description and agency organizational chart, as applicable;

k. DUI approval/licensure data and related materials;
l. Applicant history; and
m. Dated and notarized signatures pursuant to A.R.S. § 36-422 (B).

2. An application shall indicate all of the following types of behavioral health services the applicant proposes to provide:
   a. Level I behavioral health facility.
      i. Residential detoxification pursuant to R9-20-602.
      ii. Restrictive behavior management pursuant to R9-20-603.
      iii. Psychiatric acute care pursuant to R9-20-604.
      iv. Intensive treatment pursuant to R9-20-605.
      v. Court-ordered mental health evaluation and treatment to R9-20-1402.
      vi. Court-ordered alcoholism treatment pursuant to R9- 20-1403.
      vii. Crisis stabilization facility pursuant to Article 6 of this Chapter.
   b. Level II behavioral health facility.
      i. Intermediate treatment pursuant to Article 7 of this Chapter.
      ii. Court-ordered mental health treatment pursuant to R9-20-1402.
      iii. Court-ordered alcoholism treatment pursuant to R9-20-1403.
      iv. Crisis stabilization shelter pursuant to Article 7 of this Chapter.
      v. Shelters pursuant to R9-20-1301.
      vi. Halfway houses pursuant to R9-20-1308.
      vii. Basic partial care pursuant to R9-20-1602.
      viii. Intensive partial care pursuant to R9-20-1603.
   c. Level III behavioral health facility.
      i. Protective oversight residential services pursuant to R9-20-801.
      ii. Shelters pursuant to Article 13 of this Chapter.
      iii. Halfway houses pursuant to Article 13 of this Chapter.
      iv. Basic partial care pursuant to R9-20-1602.
      v. Intensive partial care pursuant to R9-20-1603.
   d. Outpatient Clinic.
      i. Outpatient treatment services pursuant to R9-20-1001.
      ii. Emergency/crisis behavioral health services pursuant to R9-20-902.
      iii. Pre-petition mental health screening pursuant to R9-20-1401.
      iv. Basic partial care pursuant to R9-20-1601.
      v. Intensive partial care pursuant to R9-20-1602.
   e. Outpatient rehabilitation agency.
      i. Outpatient treatment services pursuant to R9-20-1002.
      ii. Intensive in-home counseling pursuant to R9-20-1002(B)(1).
      iii. Home-based counseling pursuant to R9-20-1002(B)(2).
      iv. In-home supportive services pursuant to R9-20-1002(B)(3).
      v. Emergency/crisis behavioral health services pursuant to R9-20-902.
      vi. Pre-petition mental health screening pursuant to R9-20-1401.
      vii. Basic partial care pursuant to R9-20-1602.
      viii. Intensive partial care pursuant to R9-20-1603.
   f. Other behavioral health services.
      i. Case management agency services pursuant to R9-20-1101.
      ii. Assessment, evaluation and diagnosis agency services pursuant to R9-20-1201.
      iii. Shelter services pursuant to R9-20-1301.
      iv. Halfway house services pursuant to R9-20-1301.

M. A hospital or special hospital unit, licensed in conjunction with the Office of Health Care Licensure, shall make application to provide one or more behavioral health services and shall apply for a behavioral health service agency licensure. The applicant shall identify those behavioral health services, set forth in subsection (A) of this rule, which it proposes to provide. Upon determination that the hospital is in substantial compliance with all applicable rules of this Chapter, the Department shall issue a behavioral health service agency license specifying the approved program.
   1. A hospital or special hospital unit offering outpatient programs in an off-site location must identify the location of the satellite office upon application for licensure and must comply with the applicable requirements of R9-20-111, R9-20-309, and R9-20-405.
   2. A hospital or special hospital unit offering outpatient programs and which establishes an off-site location during the licensure period shall notify OBHL, in writing, of the location of the satellite office and shall comply with the applicable requirements of R9-20-111, R9-20-309, and R9-20-405.

N. Upon determination that the facility/agency is in substantial compliance with all applicable rules of this Article, the Department shall issue the agency a license to operate as a behavioral health service agency. The license certificate shall specify the services that the agency is authorized to provide and the location at which the services are based.
   1. The license certificate shall be displayed in the agency's waiting room or other conspicuous place within the agency.
   2. The license certificate shall not be altered or defaced in any manner.
   3. An expired or otherwise invalid license shall be surrendered upon Department demand.

Historical Note

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R9-20-104. Initial License

A. Behavioral health service agencies shall obtain all needed permits pursuant to A.R.S. § 36-421 and A.A.C. R9-9-301 and R9-20-103 et seq. prior to seeking initial licensure or a substantial change in services provided to clients.

B. Licensure application.
1. An applicant for an initial license shall submit an application to the Department, on forms supplied by the Department, not less than 60 days nor more than 120 days prior to the date proposed for the commencement of operation. Each service to be offered shall be described in the application. The applicant shall indicate the request for Title XIX certification of services on the application's scope of services forms.
2. The application shall be signed, in the case of an individual, by the owner of the behavioral health service agency or, in the case of a partnership or a corporation, by two of the officers thereof or, in the case of a governmental unit, by the head of the governmental department having jurisdiction thereof. Each signature shall be notarized.
3. A separate license application is required for each location when more than one facility is owned or operated by the same behavioral health service agency and for an agency operated at a single location by different persons, organizations or associations.
4. Applications for licensure of leased premises shall contain a copy of the entire lease showing clearly the responsibilities of its parties for the maintenance and upkeep of the property and that the applicant has either:
   a. Exclusive rights of possession subject only to normal and reasonable right of entry by the landlord, or
   b. That the agency has a policy for maintaining confidentiality in the provision of services and in the maintenance of client records.
5. If the behavioral health services agency has offices that serve as satellites only, a separate license application is not required for a satellite.
6. Each licensed agency shall be designated by a distinctive name which shall not be changed without written notification to the Department. Upon receiving such notification, the license will be amended.
7. Persons acquiring a behavioral health service agency license must obtain a new license at or immediately prior to transfer of ownership of the agency.

C. Upon receipt of a complete application, the Department shall conduct an on-site inspection to determine compliance with this Article at the applicant agency.

D. An initial license shall be issued for a period not more than one year pursuant to A.R.S. § 36-425. Prior to the expiration of the initial license and pursuant to A.R.S. § 41-1064, the Department shall inspect the agency to review the agency in full operation. If the agency is found to be in substantial compliance with this Article, the Department shall issue the agency a renewal license to provide authorized services.

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R9-20-105. Renewal License

A. An applicant for a renewal license shall submit an application to the Department, on forms supplied by the Department, not less than 60 days nor more than 120 days prior to the expiration date of the current license. The applicant shall indicate the request for Title XIX certification of services on the application's scope of services forms. The application shall be signed, notarized, completed and include all required attachments.

B. Upon receipt of a complete application, the Department shall request fire, safety and sanitation inspections from state or local jurisdictions and conduct an on-site inspection to determine continued compliance with this Article at the applicant agency.

C. The Department shall issue a renewal license for a period not more than one year, pursuant to A.R.S. §§ 36-425 and 41-1064, if the applicant agency is in substantial compliance with this Chapter.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency error corrected; subsection (C) deleted, subsection (D) renumbered to subsection (C) pursuant to letter received in the Office of the Secretary of State October 8, 1993 (Supp. 93-4).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-106. Provisional License

A. A provisional license shall be issued to an agency pursuant to A.R.S. § 36-425(C) if the Department determines that the agency is not in substantial compliance with this Article, based upon an application, an on-site inspection for an initial or renewal license, complaint investigations or other inspections.

B. The issuance of a provisional license shall be contingent upon submission to the Department of an acceptable plan to eliminate deficiencies.

C. A provisional license may be issued for a period of not more than one year.

D. Consecutive provisional licenses shall not be issued to a single health care institution.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency error in subsection (A) corrected pursuant to letter received in the Office of the Secretary of State October 19, 1993 (Supp. 93-4).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-107. Inspections

A. A license shall be issued only after an on-site inspection has been conducted and the agency has been determined to be in substantial compliance with statutes and rules of this Article.

B. An on-site inspection of an agency regulated pursuant to this Article shall be conducted within the 12-month period of a license unless the behavioral health service agency is a health care institution accredited by a nationally recognized accreditation organization, approved by the Department, and the agency has submitted a copy of the current accreditation report to the Director of the Department.

C. Inspections shall include each service or program location operated by the agency. The Department shall conduct unannounced audits on all complaint and incident investigations.

D. The Department shall have access to the agency and its records, including client records pursuant to A.R.S. § 36-406. The Department is authorized to interview the agency staff, clients, and care providers.

E. The Department shall conduct such other inspections or investigations as are necessary to carry out the intent and purpose of this Article and A.R.S. Title 36, Chapters 4, 5, and 18.

F. The Department shall enter upon the premises of any facility if there is reason to believe it may be operating as a behavioral health service agency without a behavioral health license.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-108. Complaint Investigations

A. Department staff shall investigate all complaints registered with the Department alleging violation of licensure statutes or rules by a behavioral health service agency. The person registering the complaint shall state the substance of the complaint and the agency by name.

B. The Department shall conduct unannounced inspections of agency locations involved in the complaint and any other investigations necessary to determine the validity of the complaint.

C. No later than ten working days after the completion of the investigation, Department staff shall prepare a written report of the results of the investigation and shall notify the complainant and the agency in writing of the results of the investigation.

D. A description of the findings of the investigation shall be sent to the complainant upon request. If legal action is taken, due process shall be followed pursuant to A.R.S. § 36-428.

E. The name of a complainant or of any client named in the complaint shall be kept confidential and shall not be disclosed without the written authorization of the individual or parent or guardian.

F. Before information regarding a complaint or its investigation is disclosed to the public or entered into Department public records, any information in the documentation of the complaint or the report of investigation which may identify the complainant or any agency client shall be deleted.

G. If the complaint becomes the subject of a judicial proceeding, nothing in this rule shall be construed to prohibit the disclosure of information which would otherwise be disclosed in a judicial proceeding.

H. Agencies shall be prohibited from discharging or discriminating in any way against any client by whom, or on whose behalf, a complaint has been submitted to the Department, or who has participated in a complaint investigation process. This prohibition shall be documented in the agency's operational policies and procedures and shall be included in the orientation for new clients.

I. Agencies shall be prohibited from discharging or discriminating against any personnel who submit a complaint, or who assist Department staff or any other legal authority in a complaint-related investigation, for reason of such submission or assistance. This prohibition shall be documented in the agency's personnel policies and procedures.

J. In addition to this administrative rule, agencies licensed pursuant to this Chapter and providing services to SMI clients are subject to the provisions of A.A.C. Title 9, Chapter 21, Article 4.

K. Violation of the prohibitions specified in subsections (H) and (I) of this rule shall be grounds for suspension or revocation of the agency's license.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-109. Plan of Correction

A. An agency found, during an inspection or other investigation, to have deficiencies in compliance with this Article shall develop a plan for correction of the deficiencies and shall submit such plan to the Department within 15 working days of receipt of the written report of the inspection or other investigation.

B. The Department shall require an immediate correction of a violation which presents an immediate threat to the health or safety of a client or one of the agency's personnel.

C. The plan of correction shall specify for each deficiency:
1. The deficiency to be corrected;
2. Action taken, or proposed, to correct the deficiency and procedures to prevent its reoccurrence; and
3. A calendar date by which the deficiency will be corrected. The date shall allow the shortest possible time within which the agency may reasonably be expected to correct the deficiency.

D. The Department shall approve, modify, or reject, in whole or in part, the plan of correction in writing within ten working days of its receipt.
1. In accepting, modifying or rejecting the plan of correction, the Department shall consider:
   a. The seriousness of the violation, including if the agency has been cited in the past for this deficiency;
   b. The nature of the actions and procedures taken, or proposed, to correct the deficiency;
   c. The time frame proposed for carrying out the correction; and
   d. Any other factors.
2. If the plan of correction is rejected by the Department, the licensed behavioral health service agency shall submit a revised plan within five days of notification that the initial plan of correction was rejected.

E. The Department shall follow such procedures as are necessary to verify the correction of any deficiency identified during a routine licensure inspection or other investigation that has been conducted.

F. A behavioral health care institution may request a hearing to have a legal order, licensure decision, or deficiency statement reviewed by submitting a written request to the Department's Office of Administrative Counsel within 30 days of receipt of notice pursuant to A.R.S. § 41-1064.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-110. Department Reports and Records

A. A report of any inspection or investigation made by the Department shall be in writing and on file with the Department. If deficiencies are determined, the report shall specify its nature and indicate the rule violated.

B. Reports and records related to these rules shall be public information, except with regard to complaint investigations as specified in R9-20-108.

C. When an inspection report is released prior to the agency's submission, or the Department's review, of a plan of correction, such fact shall be identified with the release.

D. The Department shall provide copies of materials available for public information upon request and may charge a fee to cover the cost of materials, staff time, and equipment, according to Department policy.

E. Agencies licensed pursuant to this Chapter and providing services to SMI clients are subject to the provisions of A.A.C. Title 9, Chapter 21.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4).

R9-20-111. Required Reports

A. A licensed agency providing direct services at the time of the incident shall report to Health & Child Care Review Services, OBHL, accidents or incidents involving clients in the following situations:
1. Client deaths from suicides, homicides, deaths resulting from unexplained or accidental causes and deaths from expected or natural causes;
2. Suicide attempts resulting in emergency room treatment or hospitalization, or requiring medical intervention;
3. Self abuse resulting in emergency room treatment or hospitalization or requiring medical intervention;
4. Physical abuse and allegations of physical abuse;
5. Sexual abuse and allegations of sexual abuse;
6. Physical injuries received in a treatment setting resulting in emergency room treatment or hospitalization;
7. Errors in administering medications requiring emergency medical intervention;
8. Adverse medication reactions resulting in medical intervention;
9. Inpatient hospitalized clients and clients in a residential treatment setting who have not been accounted for when expected to be present or are absent without leave (AWOL);
10. Accidents occurring in the treatment facility or off-site, while under the supervision of the treatment facility's staff, requiring emergency medical treatment, which are not limited to near drownings that require resuscitation; and
11. Physical plant disasters, such as major fire within the agency when clients were present or which affect client care areas.

B. An agency shall report accidents or incidents as specified in subsection (A) of this rule by telephone to OBHL within one working day or 24 hours of the event and followed with a written report within five days, excluding weekends. The written report shall contain the following information:
1. Agency name, license number and classification;
2. Identification of any individuals affected by, or involved in, the event;
3. If an affected individual is, or was at the time of the reported event, a client of the agency, the following shall also be included in the report:
   a. Date of admission,
   b. Current diagnosis,
   c. Physical and mental status prior to the event, and
   d. Physical and mental status after the event.
4. The location, nature and brief description of the event;
5. The name of the physician consulted, if any, time of notification of the physician and a report summarizing any subsequent physical examination, including findings and orders;
6. The name of any witnesses to the event;
7. Other information deemed relevant by the reporting authority;
8. Action taken by the agency; and

9. The signature of the person who prepared the report, the signature of the administrator or administrator's designee and the date when the report was prepared.
10. OBHL shall review the submitted records and investigate and refer to other governmental agencies or individuals as indicated.

C. An agency shall maintain records of the use of all locked seclusion or mechanical restraint for review by the OBHL.

D. An agency shall report all suspected cases of client abuse or neglect to the Department's OBHL or Office of the SMI, the DES, Office of Adult Protective Services or Child Protective Services, and any other required authority immediately upon detection in accordance with A.R.S. § 13-3620. If such abuse or neglect occurs while the client is under the supervision of agency personnel, the agency shall also follow reporting requirements of subsection (A) of this rule.

E. A report shall be made by agency staff, within 24 hours, to the agency's administrator of all violations or suspected violations of a client's rights, except immediate notification shall be made in the case of physical or sexual abuse. Such reports shall be kept on file at the agency and available for review by Department staff.

F. A report of the findings of an investigation regarding any violation, or suspected violation, and the administrator's actions taken to preclude repetition shall also be kept on file and available for Department review.

G. The agency shall maintain at each site where services are provided to clients, including satellite offices, a current copy of fire safety inspection reports, documentation that all requested corrections have been completed, and a copy of fire drill reports conducted no less than on a quarterly basis. These reports shall be made available to the Department for inspection until the next annual licensure survey.

H. Agencies which provide food or food services as a part of their program shall also maintain at the site, including satellite offices, current sanitation inspection reports issued by the authority of local jurisdiction and documentation that all requested corrections have been completed.

I. An agency shall provide such other reports to the Department as are required to determine compliance with applicable requirements of this Article.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-112. Client Fees and Charges

A. An agency shall provide to the Department's Office of Health Economics and to any client, parent, guardian or designated representative if the client is a child at the time of admission, a schedule of fees which a client may incur during that admission. If the schedule of fees and charges contains a provision for reduced charges based on ability to pay, criteria for determining the applicant's ability to pay must be clearly stated.

B. New fee schedules or new payment criteria shall be posted in a prominent place and available for review by the clients, parents, guardians or designated representative no less than 30 days before the change becomes effective, or a letter addressing the new fee schedules or payment criteria shall be mailed to all registered clients of the agency and to the Department no less than 30 days prior to the effective date of the change.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-113. Research

A. An agency shall establish a Human Subject Review Committee prior to engaging in research activities or allowing its personnel, clients, records or facilities to be used for research purposes.

B. The Human Subject Review Committee shall develop written policies and procedures for carrying out research activities which include, but need not be limited to:
1. Guidelines for ensuring the rights of all human subjects and provisions for protection of client anonymity both during the research and following publication of the results, and
2. Supervision by a physician where bodily integrity may be violated.

C. The Human Subject Review Committee shall approve or disapprove research proposals or requests for agency data from any source in accordance with adopted policies and procedures. The Human Subject Review Committee will approve or disapprove such proposals or requests based on protection of the human subjects' privacy, maintenance of data confidentiality and personal safety from any test, procedure or interview.

D. The written informed consent of all clients participating in any research project shall be obtained prior to participation.

E. Agencies licensed pursuant to this Chapter and providing services to SMI clients must comply with the provision of A.A.C. Title 9, Chapter 21.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption

from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-114. Grievance Procedure

A. The licensed behavioral health service agency shall have policies and procedures for clients to grieve alleged violations of this Chapter.

B. The procedures shall be clearly written for understanding by the agency's client population, include specific steps to be taken by both the grievant and the agency, and timelines by which responses shall be issued to the grievant by the agency.

C. The address and telephone number of the Department's OBHL shall be included in information provided to clients, family members, custodial agencies, guardians, or designated representatives regarding grievances and reporting of complaints regarding violations of licensure statutes or rules.

D. Agency grievance policies and procedures shall be explained to the client, parent, guardian or designated representative at the time of admission. Understanding of the grievance policies and procedures shall be verified by the dated signature of the client, parent, guardian or designated representative.

E. Agencies licensed pursuant to this Chapter and providing services to SMI clients must comply with the provision of A.A.C. Title 9, Chapter 21, Article 4.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

ARTICLE 2. CLIENT RIGHTS

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-201. Client Rights

A. All clients shall be afforded the following basic rights:

1. The right to treatment and services under conditions that support the client's personal liberty and restrict such liberty only as necessary to comply with treatment needs;
2. The right to an individualized written treatment plan, periodic review and reassessment of needs, and revisions of the plan including a description of the services that may be needed for follow-up;
3. The right to ongoing participation in the planning of services to be provided as well as participation in the development and periodic revision of the treatment plan, and the right to be provided with an explanation of all aspects of one's own condition and treatment;
4. The right to refuse treatment as outlined in A.R.S. §§ 36-512 and 36-513;
5. The right to refuse to participate in experimentation without the informed, voluntary, written consent of the client, parent or guardian; the right to protection associated with such participation; and the right and opportunity to revoke such consent;
6. The right to freedom from restraint or seclusion. Restraint and seclusion may only be used in situations where there is imminent danger that the client will injure self or others or to prevent serious disruption of the therapeutic environment, and all other less restrictive methods of control have been exhausted;
7. The right to a humane treatment environment that affords protection from harm, appropriate privacy, and freedom from verbal or physical abuse;
8. The right to confidentiality of records;
9. The right to access, upon request, to the client's own client records in accordance with state law;
10. The right to be informed of all rights in the client's primary language;
11. The right to legal counsel and all other requirements of due process;
12. The right to not be subjected to remarks which ridicule the clients or others;
13. The right to refuse to make public statements acknowledging gratitude to the program or perform at public gatherings;
14. The right to assert grievances with respect to infringement of these rights, including the right to have such grievances considered in a fair, timely, and impartial procedure;
15. The right of access to an advocate in order to understand, exercise, and protect the client's rights;
16. The right to be informed, in advance, of charges for services;
17. The right to all existing services without discrimination because of race, creed, color, sex, age, handicap, national origin, or marital status and the right to referral, as appropriate, to other providers of behavioral health services;
18. The right to a smoke-free environment as stated in the agency's policies and procedures; and
19. The right to exercise the client's civil rights including, but not limited to, the right to register and vote at elections, the right to acquire and dispose of property, execute instruments, enter into contractual relationships, to marry and obtain a divorce, to hold professional or occupational or vehicle operator's licenses, unless the client has been adjudicated incompetent or there has been a specific finding that such individual is unable to exercise the specific right or category of rights. When a client is adjudicated incompetent, the client's civil rights may be transferred to the client's guardian, if so specified by the court.

B. Client rights relating to medications:

1. All clients receiving services in a licensed behavioral health service agency shall have a right to be free from unnecessary or excessive medication.
2. Medication shall not be used for the convenience of the staff, as punishment, as a substitute for treatment services, or in quantities that interfere with the client's treatment program.

C. Agencies shall post a list of client rights in a conspicuous area accessible to all clients. Agencies shall provide a copy of the client rights to any client, family member or designated representative upon request.

D. Agencies shall post, in the waiting area or public access area and at the telephone available for client use, the telephone numbers of the DES Offices of Adult Protective Services or Child Protective Services, and DES Community Care Licensure, and the Department's OBHL.

E. The agency's space and furnishings shall be arranged to enable the staff to provide supervision while respecting the clients' right to privacy.

F. In residential programs, the client shall be allowed private and uncensored communication and visits with family members or other visitors when such visits do not interfere with treatment activities or are not contraindicated by the client's treatment plan or court order.
1. Restriction of communication or visits required for therapeutic reasons, including the expense of travel or telephone calls, shall be determined with the client, the client's parent, family, designated representative or guardian and be documented in the client's record.
2. The behavioral health service agency providing residential treatment or care shall endeavor to carry out the rights guaranteed above by making telephones accessible, by ensuring that correspondence can be received and mailed, and by making space available for visits.
3. Times and places for visits and the use of telephones may be established in writing.
4. Clients shall be housed with other individuals of similar chronological or developmental age and activity level unless specific reasons, such as the need to protect a client with a low level of adaptive skills and ability for self-defense, are noted in the treatment plan.
5. Clients may engage in labor if the labor is compensated in accordance with the Fair Labor Standards Act, 29 U.S.C. 206, or the state minimum wage law, whichever is more stringent.
6. Agency maintenance and housekeeping chores shall not be dependent upon client labor except in accordance with subsection (F)(5) of this rule. As part of the treatment plan, clients may participate in routine household activities designed to enhance or develop independent living skills functioning in accordance with an individualized treatment plan.

G. Photographs of a client shall not be used by an agency without written consent from the client, the client's parent or guardian. Before any such pictures are used, a dated and signed consent form indicating how they will be used shall be placed in the client's record.

H. Clients shall be allowed to wear their own clothing unless contraindicated by the treatment plan or agency policy.
1. Training and assistance in the selection and proper care of clothing shall be available.
2. Clothing shall be suited to the climate.
3. Clothing shall be in good repair, of proper size and similar to the clothing worn by the client's peers.
4. Agencies may establish dress codes.

I. Agencies licensed pursuant to this Chapter and providing services to SMI clients must meet the additional requirements stated in A.A.C. Title 9, Chapter 21.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

ARTICLE 3. AGENCY ADMINISTRATION

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-301. General Agency Administration

A. A behavioral health agency shall be organized and administered under one governing authority which may be a proprietorship, partnership, association, corporation, or governmental unit.

B. An agency governing authority shall appoint an administrator who shall meet the qualifications and carry out the responsibilities specified in R9-20-302.

C. The agency governing authority and administrator shall adopt a written program statement of activities including a statement of purpose, program goals, a detailed description of the type of services offered, hours of operation, populations served, admission criteria, policies regarding fee payment, provisions for special needs of clients, client/staff ratios and staff qualifications.

D. An agency shall have written policies and procedures that address all aspects of the agency's operation which at a minimum include requirements of this Article.
1. Such policies and procedures shall be reviewed and updated every 12 months.
2. Upon completion of initial development or any change or update, the policy or procedure shall be dated and signed as effective by the agency administrator or the chairperson of the agency's board of directors.
3. Agency staff shall be informed of all initial and updated policies and procedures applicable to their employment status and shall be familiar with such documents within 30 days of policy and procedure initiation.
4. Documentation of the employee's review shall be maintained.

E. An agency shall have written policies and procedures which address referrals of clients to a full range of services for the treatment of illness and maintenance of general health or necessary social services.

F. An agency shall have written policies and procedures which address the appointment of a staff member to act as administrator or clinical director in the absence of administrator or clinical director. The staff member shall be 21 years of age or older. The policy shall include a statement of the circumstances under which the qualified staff member will act and ensure that the designee has full access to all areas within the facility and facility grounds that are related to care, supplies, and safety.

G. The governing body shall maintain in the administrative offices of the agency a current list of names and address of all persons or entities having a 10% or more ownership interest as well as copies of all deeds, leases, land sale contracts or other documents evidencing control or ownership of the real property.

H. The following documents or copies shall be available in the administrative office of each agency:
1. Bylaws of the governing body;
2. Policies and procedures for all services;
3. Reports of all inspections and reviews related to licensure for the preceding five years together with corrective actions taken;
4. Contracts and agreements related to licensure to which the agency is bound;
5. Documents evidencing control or ownership; and
6. A current copy of statutes and rules pertaining to behavioral health services agencies.

I. In agencies which have programs for children, services may be provided to a child in a children' s program beyond the child's 18th birthday provided that the child has been placed prior to the 18th birthday and is in the process of completing a high school education program, graduate equivalency diploma program, or a job training program and meets the requirements of R9-20-502(H)(7)(f).

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency errors in subsections (F) and (I) corrected pursuant to letter received in the Office of the Secretary of State October 8, 1993 (Supp. 93-4).

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R9-20-302. Administrator

A. The agency administrator shall have a combination of education and experience to perform the duties outlined in the job description and which demonstrate competence to perform administrative duties specified in these rules and assure the agency is operating in substantial compliance with this Article. The agency administrator shall be 21 years of age or older. Documentation of qualifications shall be included in the administrator's personnel file pursuant to R9-20-309.

B. The administrator shall be in charge of the management and business affairs of the behavioral health service agency and shall be fully authorized and empowered to carry out the provisions of this Article.

C. The administrator shall be responsible for the completion, keeping or submission of such reports and records as may be required by the Department.

D. The administrator is responsible for compliance with all policies and procedures pursuant to R9-20-301 and shall provide the staff access to all records necessary for the performance of these duties.

E. The administrator is responsible for ensuring that an agency providing residential services to children shall have an educational component approved by the Arizona Department of Education, or arrange for the educational needs of the clients through the local school system.

F. No less than 15 working days prior to changing the administrator, an agency shall notify the Department, in writing, of the new administrator. The written notification shall include qualifications of the newly appointed administrator and the date when the change shall take place. In instances when permanent transfer of administrator responsibilities occurs unexpectedly, the agency shall notify the OBHL of such change within 24 hours of the change in administrators by telephone and provide written verification within five working days following the change.

G. The administrator shall designate, in writing, an acting administrator who shall be 21 years or older and who shall have access to all areas within the agency that are related to client care when the administrator is absent from the facility premises.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-303. Clinical or Program Director

A. The agency shall employ a clinical or program director who is responsible for its clinical or treatment programs and to perform other responsibilities outlined in the job description. The clinical or program director shall have, at a minimum, a combination of six years of behavioral health education and experience.

B. The clinical or program director shall be responsible for the overall clinical operation of the agency. Such responsibilities shall be specified in the job description and shall include:

1. Development and approval of general behavioral health service delivery policies and procedures;
2. Development and approval of medication policies and procedures;
3. Determination of the types of staff training programs to be provided by the agency for its personnel;
4. Establishment of a process by which the agency will evaluate the quality of client record documentation, counseling services, evaluation, and diagnosis;
5. Establishment and enforcement of policies and procedures for clinical supervision of agency personnel;
6. Establishment of the qualifications necessary for agency personnel to deliver behavioral health services included in the agency program statement; and
7. Ensuring that each client receives the appropriate care in accordance with the client's treatment plan and regardless of the source of payment for services.

C. The clinical director shall comply with the policy and procedures required pursuant to R9-20-301 and have access to all records necessary to the performance of these duties.

D. No less than 15 working days prior to changing the clinical or program director, the agency shall notify the Department, in writing, of the new director. The written notification shall include qualifications of the newly appointed director and the date when the change shall take place. When permanent transfer of clinical director responsibilities occurs unexpectedly, the agency shall notify the OBHL of such change within 24 hours of the change in directors by telephone and provide written verification within five working days of the change.

E. The clinical or program director shall designate, in writing, an acting director who shall be 21 years or older and who shall have access to all areas within the agency that are related to client care when the director is absent from the facility premises.

Historical Note

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R9-20-304. General Personnel Requirements

A. Policies and procedures.
1. An agency shall establish written policies describing the duties, responsibilities, and required minimum qualifications of its personnel.
2. Personnel policies shall include standards governing the ethical conduct of staff and volunteers, and confidentiality of information regarding clients and client records.
3. Agencies which utilize volunteers shall have written policies and procedures governing volunteer services that include screening of applicants, training, supervision, and documentation of such supervision.

B. An agency shall have an organizational chart identifying all staff positions. The chart shall clearly indicate lines of supervision, authority, and accountability.

C. At all times when clients are on the premises, one staff member shall be required to hold a valid driver's license.

D. An agency shall develop and implement policies and procedures governing supervision of all agency personnel and documentation of such supervision.

E. Supervision and related documentation of personnel providing direct clinical services shall include a review and any resulting recommendations for, at a minimum, the following:
1. Participation in counseling activities,
2. Skills in client recordkeeping,
3. Therapeutic capabilities in providing services to clients, and
4. Any training needed to improve the personnel's job performance.

F. A performance evaluation shall be conducted a minimum of once every 12 months by the assigned supervisor for all agency personnel and documented in the personnel file.

Historical Note

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R9-20-305. Notice of Conviction; Fingerprinting of Staff Members Providing Behavioral Health Services Directly to Children or to Clients in Domestic Violence Shelters

A. Documentation shall be maintained at the agency which verifies agency compliance with A.R.S. §§ 13-3716 and 36-425.03 for service delivery to children and A.R.S. § 36-3008 for shelters which provide services to victims of domestic violence.

B. An agency shall not allow any person to provide behavioral health services directly to children who has been convicted of, or admits to committing, any criminal offenses listed in A.R.S. § 36-425.03(E) and (F). Domestic violence shelters shall not allow any person to provide services directly to clients who has been convicted of, or admits to committing, any criminal offenses listed in A.R.S. § 36-3008(D).

C. An agency shall not allow any person, to provide behavioral health services to children without supervision, if the person has been convicted of, or has admitted committing, any criminal offenses listed in A.R.S. § 36-425.03(G) or any other criminal offenses if the Department determines there is a reasonable basis to conclude that the person's presence in the agency may have a detrimental effect on children.

D. Volunteers who provide services to children under the direct visual supervision of staff of a licensed behavioral health service agency are exempt from review pursuant to A.R.S. § 36-425.03(J).

Historical Note

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R9-20-306. Personnel Qualifications

A. Qualifications for physicians, physician assistants, psychiatrists, psychologists, nurses, nurse practitioners, social workers, and counselors shall comply with statutory requirements and professional or occupational licensure, certification or registration standards.

B. Behavioral health professionals are staff who meet one of the following requirements:
1. A psychiatrist shall be a licensed physician as defined in A.R.S. Title 32, Chapter 13 or 17, who is Board certified or Board eligible under the standards of the American Board of Psychiatry and Neurology or the Osteopathic Board of Neurology and Psychiatry;
2. Psychologists providing behavioral health services shall be licensed by the Arizona Board of Psychologist Examiners in accordance with A.R.S. Title 32, Chapter 19.1;
3. Social workers providing behavioral health services shall be certified by the Arizona Board of Behavioral Health Examiners pursuant to A.R.S. Title 32, Chapter 33. Social workers may, in lieu of state certification, meet the criteria for certification by the National Academy of Certified Social Workers;
4. Counselors are professional counselors, marriage and family therapists and substance abuse counselors who engage in the practice of professional counseling:
   a. Professional counselors shall be certified by the Arizona Board of Behavioral Health Examiners pursuant to A.R.S. Title 32, Chapter 33. Professional counselors may, in lieu of state certification, meet

the criteria for certification by the National Academy of Certified Clinical Mental Health Counselors;

b. Marriage and family therapists providing behavioral health services shall be certified by the Arizona Board of Behavioral Health Examiners pursuant to A.R.S. Title 32, Chapter 33. Marriage and family therapists may, in lieu of state certification, be certified by the American Association of Marriage and Family Therapy;

c. Substance abuse counselors providing behavioral health services shall be certified by the Arizona Board of Behavioral Health Examiners pursuant to A.R.S. Title 32, Chapter 33. Substance abuse counselors may, in lieu of state certification, be certified by the Arizona Board of Certification of Addiction Counselors;

5. Nurse practitioners providing behavioral health services shall be licensed by the Arizona Board of Nursing pursuant to A.R.S. Title 32, Chapter 15.
6. Physician assistants providing behavioral health services shall be licensed by the Arizona Board of Medical Examiners pursuant to A.R.S. Title 32, Chapter 25.
7. Registered nurses providing behavioral health services shall be licensed by the Arizona Board of Nursing pursuant to A.R.S. Title 32, Chapter 15 and shall have one year of work experience in the behavioral health field.

C. Behavioral health technicians providing therapeutic services to clients shall meet one of the following conditions:
1. A bachelor's degree in a behavioral health or health-related field;
2. A bachelor's degree in any field, plus one year of work experience in behavioral health service delivery; or
3. A high school diploma or general education diploma (GED) and a combination of behavioral health education and work experience totaling a minimum of four years.

D. Behavioral health paraprofessional staff providing therapeutic services to clients shall meet one of the following conditions.
1. A paraprofessional shall possess a high school diploma or have completed a general equivalency program or have received an associate degree from an accredited community college.
2. The paraprofessional shall be supervised by a person licensed or certified under A.R.S. Title 32, or a behavioral health professional pursuant to R9-20-306(B), or a person meeting the requirement of R9-20-307(B).

E. The agency shall determine and document the competency of behavioral health technicians and paraprofessionals in the following areas prior to allowing the individual to provide service to any client:
1. Prevention of violent behavior or behavior harmful to the client or others;
2. Behavior management in crisis situations;
3. Symptomatology of agency clients' diagnosed mental disorders or addictions;
4. Indications, common side effects, reactions and interactions of medications prescribed for self-administration by agency clients;
5. Behavior management skills and activity supervision;
6. Resources for obtaining assistance when needed;
7. Client recordkeeping of client activities and progress toward treatment goals and objectives; and
8. Skill in the provision of recreational and social activities, life skills training, and milieu activities.

F. Case managers or case coordinators are staff who meet one of the following qualifications:
1. Hold a bachelor's degree in a human services field;
2. Hold a bachelor's degree in any field and have one year of work experience in behavioral health service delivery;
3. Hold a high school diploma or have completed a general equivalency program or have received an associate degree from an accredited community college and have a combination of behavioral health education and work experience totaling a minimum of four years.

G. The agency shall determine and document the competency of the case manager or case coordinator in the following areas prior to allowing the individual to provide service to a client.
1. Symptomatology of agency clients' diagnosed mental disorders or addictions;
2. Indications, common side effects, reactions and interactions of medications prescribed for self-administration by agency clients;
3. Resources for obtaining assistance when needed; and
4. Client recordkeeping of client activities and progress toward treatment goals and objectives.

H. All staff members who provide treatment services to clients of a licensed behavioral health service agency shall be 21 years of age or older. Volunteers and interns placed through an academic program operated by an accredited college or university shall be 18 years of age or older.

I. Specific staff qualification requirements shall be in the agency's written policies and procedures. The qualification requirements shall relate to service categories offered by the agency.

J. Qualification requirements and service descriptions for interns and volunteers shall be in the agency's written policies and procedures.

Historical Note

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R9-20-307. Clinical Supervision

A. Clinical supervision shall be directed by a clinical or program director who is a licensed psychiatrist, psychologist, or certified behavioral health professional. The clinical director or program director may be an employee or contract personnel.

B. Direct clinical supervision of behavioral health technicians and behavioral health paraprofessionals shall be provided by an individual who is:
1. A psychiatrist licensed pursuant to A.R.S. Title 32, Chapter 13 or 17, or;
2. A psychologist licensed pursuant to A.R.S. Title 32, Chapter 19.1; or
3. Certified by the Arizona Board for Certification of Addiction Counselors; or
4. Certified by the Board of Behavioral Health Examiners pursuant to A.R.S. Title 32, Chapter 33; or
5. Credentialed by a national organization recognized by the Department as having standards that are equal to the

requirements of paragraph (1), (2), or (3) of this subsection; or

6. The holder of an associate's degree in a field of study related to human services granted by an accredited college or university and the holder has a minimum of five years' work experience relevant to the person's area of supervision; or
7. The holder of a bachelor's degree in a field of study related to human services granted by an accredited college or university with a minimum of three years' work experience relevant to the person's area of supervision; or
8. The holder of a master's degree in a field related to human services granted by an accredited university with a minimum of two years' work experience relevant to the person's area of supervision; or
9. The holder of a doctorate in a field of study related to human services from an accredited university with a minimum of one year of work experience relevant to the person's area of supervision; or
10. A registered nurse who has a minimum of one year of work experience in a behavioral health setting.

C. Agencies shall have documentation that supervisory sessions have occurred on a regular basis as follows:

1. Every behavioral health technician and behavioral health paraprofessional staff employed by a hospital or Level I behavioral health facility shall receive a minimum of one hour per week of clinical supervision from a behavioral health professional or clinical supervisor meeting the requirements of R9-20-307(A).
2. Every behavioral health technician and behavioral health paraprofessional staff employed by a licensed behavioral health facility not listed in paragraph (1) above shall receive a minimum of four hours per month of clinical supervision.

Historical Note

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R9-20-308. Staff Development and Training Requirements

A. An agency shall establish a plan to provide initial orientation and ongoing training for staff that clearly describes the type of training necessary to maintain current skills, to obtain new skills, and which relates to the goals and objectives of the agency program plan for services offered.

B. The training shall place special emphasis on treatment policies and procedures, client rights, crisis management techniques and procedures to be followed in behavioral health/psychiatric emergencies, medical emergencies and other emergency situations.

C. Staff development and education programs shall be planned and conducted on a regular and continuing basis for all employees who provide direct services to clients and for all case managers. The agency shall provide or ensure that each staff member participates in a minimum of 48 hours of orientation, continuing education and in-service training for newly hired staff during the employee's first year or a minimum of 24 hours of continuing education or in-service training for subsequent years.

1. Documentation of these sessions shall include date, subject, number of hours, attendance as verified by the signature of the staff member and respective job title, and the instructor's name. The document shall be maintained for each employee at a central location.
2. Records of attendance at professional workshops and conferences shall be maintained for each employee at a central location.
3. Time spent in orientation shall be credited toward an employee's first year of annual in-service hours.

D. All staff shall attend an orientation session within the first week of employment. Orientation shall include:

1. Review of the facility's policies and procedures, including personnel policies;
2. Client rights;
3. Protection of client privacy and confidentiality;
4. Facility rules;
5. Fire, safety and emergency procedures; and
6. Basic infection control techniques, including hand washing, prevention of communicable diseases, and linen handling, if applicable.

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R9-20-309. Personnel Files

A. The agency shall maintain a current, individual file of the agency's full-time and part-time personnel which includes:

1. Individual' s name, birth date, address and phone number;
2. Name and telephone number of the person, physician, or health facility to be notified in case of emergency;
3. Documentation that the staff member or volunteer meets qualifications specified in these rules and included in the job description to provide assigned behavioral health services. Documentation shall include a record of dates and locations of work experience, education, and training;
4. Dates of employment or volunteer assignments;
5. A copy of required licenses or certifications;
6. Documentation of compliance with A.R.S. § 36-425.03 required of all staff members providing direct care services to children;
7. Documentation of clinical supervision sessions as defined in R9-20-307;
8. Documentation of written performance evaluations, conducted a minimum of every 12 months, including the signature of the employee or volunteer acknowledging receipt of the evaluation;
9. Documentation of any disciplinary actions taken against the staff member or volunteer;
10. Documentation of cardiopulmonary resuscitation and first-aid training, if applicable;
11. Documentation of continuing education or training; and
12. A copy of the individual's current job description and required qualifications with a dated signature by the employee indicating that the employee understands and is

in agreement that the employee meets stated qualifications and experience requirements and can adequately perform duties described therein.

B. The personnel files of all behavior health facilities providing 24-hour care, including hospitals, Levels I, II or III behavioral health facilities shall also include:
1. Documentation of a physical examination, prior to providing direct services to clients, which demonstrates a medical status which will not conflict with primary job duties intrinsic to the position.
2. Documentation of annual tuberculin test which shows negative results by:
   a. A report of a negative Mantoux skin test made within six months prior to the date of employment and annually thereafter; or
   b. A written statement from a physician made within six months of employment and annually thereafter, stating that upon an evaluation of a positive Mantoux skin test, or history of a positive Mantoux skin test, the individual was found to be free from tuberculosis.

C. Personnel files shall be maintained in one central location within the agency and shall be made available in a timely manner upon request for inspection by the Department for one year following termination of employment or volunteer work.

D. Personnel files for staff employed or assigned to satellite offices shall be maintained at the satellite office only if the location for the files is documented in the initial or renewal licensure application.

Historical Note

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R9-20-310. Staffing Requirements

A. The agency shall be staffed to acuity with qualified staff and supporting personnel to provide the quantity and type of services set forth in the agency's written program statement.

B. Staff qualifications shall be in accordance with the level of care required by clients and the client admission and discharge criteria of the agency.

C. Psychotherapy, group therapy, or individual counseling shall be conducted by or under the supervision of a psychiatrist, psychologist, or a behavioral health professional.
1. Group therapy or individual counseling may be provided by a behavioral health technician, who shall be supervised by a clinical supervisor pursuant to R9-20-307(B), a behavioral health professional, a psychologist, or a psychiatrist.
2. Psychotherapy shall be rendered by a psychiatrist, a psychologist, or a behavioral health professional licensed or certified pursuant to A.R.S. Title 32.

D. At a minimum, one staff member shall be on the premises and awake at all times when clients are present at the agency with a minimum of one other staff member on call and readily available to relieve or assist in cases of emergency.

E. There shall be a minimum of a nurse or one staff member with current certification in first-aid training and one staff member with current cardiopulmonary resuscitation certification from a program approved by the American Heart Association or the American Red Cross on the premises at all times when the agency is open and clients are present and on staff-supervised outings from the agency. One staff person may meet both certification requirements.

F. The licensed behavioral health service agency which provides food services shall have personnel to prepare and serve food.

G. An agency shall have staff to maintain the agency in a clean and safe manner. Maintenance and cleanliness of the agency shall not be dependent upon the work of the clients.

H. For agency swimming and water activities, the agency shall meet the requirements specified in R9-20-506.

I. Each agency shall maintain staffing and census records for the preceding six months.

J. When transportation is provided, or on outings, staffing shall be based on acuity.

K. For transportation or outings lasting four hours or more where emergency medical services cannot respond within 12 minutes, two or more staff shall be required when two or more clients are present.

Historical Note

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R9-20-311. Health and Safety

A. The temperature of the hot water supply for patient care areas shall be regulated between 90° F. and 115° F. as measured at the outlet.

B. Any electrical fans, except ceiling paddle fans, shall be screened. All electrical fans, including paddle fans, shall be placed in safe locations.

C. The use of unvented or open-flame space heaters shall be prohibited.

D. All potentially dangerous objects or toxic substances shall be stored in a locked cabinet or enclosure, away from food or other areas that could constitute a hazard to the client.

E. A copy of the agency's written plan of evacuation in cases of fire or other disaster shall be conspicuously posted throughout the agency.

F. Every behavioral health service agency providing residential treatment or care shall have policies and procedures regarding unauthorized entry to or exit from the unit by clients, staff and other persons.

G. Behavioral health service agencies providing residential treatment or care shall have a written policy governing smoking in the agency, including:
1. Designated smoking areas shall be conspicuously posted and made known to all clients, staff and visitors;
2. Smoking shall be prohibited in any area of the agency where combustible supplies, materials, liquids or gases are in use or stored;

3. In agencies which permit smoking, ambulatory clients shall not be permitted to smoke in bed; non-ambulatory clients shall be allowed to smoke in bed only if one of the agency's staff members is in the room during the time the client is smoking; and
4. Wastebaskets and ashtrays shall be made of noncombustible materials, and wastebaskets shall not be used as ashtrays.

Historical Note

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ARTICLE 4. CLIENT SERVICE REQUIREMENTS

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R9-20-401. Admission and Discharge Criteria

A. The agency shall develop and implement written policies and procedures that address its admission and discharge criteria and meet the requirements of this rule.

B. There shall be written admission criteria with specific detail to allow prospective clients and referring agencies to understand admission policies.
1. It shall be the responsibility of the administrator to accept for admission clients whose needs do not exceed the agency's program capabilities and qualifications or the range of services for which the agency is licensed.
2. A description shall be included of conditions under which a client will be immediately admitted, put on waiting list, denied or referred to another agency.
3. Additional eligibility criteria may be developed if such criteria are needed to insure that clients admitted by the agency are compatible with the agency's capability to provide services, or to further delineate the minimum skills or behaviors that a person needs to function in the agency's environment.
4. Any unique admission provisions relating to the admission of clients who are involuntarily referred for treatment or evaluation under court order must be stated in detail and accompanied by a description of all special care, treatment, and discharge restrictions which may attend the client's involuntary status.

C. There shall be written treatment discharge criteria, with specific detail to allow a client reaching the stage of possible discharge to understand expected performance in relation to the individual treatment goals, and to assure clients who are involuntarily discharged that the decision to terminate treatment was neither arbitrary nor capricious.
1. Discharge criteria shall include provisions that the client be advised of the reason for termination, and the opportunities, if any, available to the client to gain readmission.
2. No client shall be involuntarily terminated while physically dependent upon any addicting medication prescribed as part of the client's treatment by the agency unless the client is offered an opportunity to detoxify or provided with agency referrals for detoxification from the substance prior to discharge.
3. Discharge criteria shall not apply when a client is a danger to program staff or other clients or voluntarily leaves a program without giving prior notice.

D. A discharge, termination or transfer summary shall be included in the client's record when the client transfers from a program or facility.

E. If a client is involuntarily discharged from the agency, prior to the client leaving the agency, personnel shall review the agency's grievance policies and procedures with the client and inform the client of all rights to grieve the discharge.

F. The agency shall have specific procedures for the review of clinical decisions regarding client admission and discharge.

Historical Note

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R9-20-402. Client Assessment

A. The agency shall have written procedures concerning coordination of initial assessments and any additional evaluation and formulation of treatment plans.

B. The initial assessment shall be entered in a client's record within five working days of the intake interview by the service delivery agency and shall include the following:
1. Presenting issues;
2. Social history;
3. Medical history with documentation of known allergies, required special diets and current and past medications;
4. Educational and vocational history;
5. Substance abuse history if applicable;
6. Legal status assessment and history;
7. History of past treatment and hospitalization for behavioral health issues;
8. Information obtained from the interview with the client, his parent or guardian; and
9. Recommendations for further assessment and initial treatment prior to finalization of treatment plan.

C. Based on initial assessment information obtained during the intake interview, staff shall determine the need for and make recommendations regarding additional evaluation. Recommendations for any additional evaluation shall be entered in the record within five working days after intake and may include the following:
1. Psychiatric or psychological evaluation,
2. Physical examination,
3. Neurological examination,
4. Laboratory tests,
5. Educational testing,
6. Occupational and recreational therapy evaluations,
7. Rehabilitation and vocational evaluation,

8. Adaptive behavior evaluation or direct observation of behavior,
9. Nutritional evaluations including specialized nutrition or dietary modifications, and
10. Speech and language evaluations.

D. Additional information about the client's condition resulting from any evaluations shall be recorded immediately in the client's record.

E. When diagnoses are rendered, they shall be:
1. Written in standard nomenclature as provided in the American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised, Washington, D.C., American Psychiatric Association, 1987, which is herein incorporated by reference and on file in the Office of the Secretary of State; and
2. Substantiated by data based upon accepted professional standards of examinations and tests and indicated by factual description of client symptoms and issues.

F. Agencies licensed pursuant to this Chapter that provide services to SMI clients shall also meet the requirements stated in A.A.C. Title 9, Chapter 21.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-403. Staffing Requirements for Assessment Services

A. Agency staff providing assessment services specified in R9-20-402(B) shall, at a minimum, meet qualifications for a behavioral health technician.

B. Assessment services specified in R9-20-402(C) shall be conducted by agency staff or contract personnel who are licensed or certified under A.R.S. Title 32.

C. Staff shall be available to provide assessment services during the agency's hours of operation. The agency shall have policies and procedures for referral of clients to another agency for assessment if such services are needed during hours when the agency is not in operation.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-404. Treatment or Services Planning

A. An agency shall prepare a written plan of treatment and service for all clients based on the initial evaluation of treatment needs, resources of the agency and consistent with the service or treatment plan prepared by another agency, a qualified clinician, a case manager, or a case management team.
1. Emergency/crisis behavioral health services, psychiatric acute care, detoxification and hospital treatment plans shall be developed and put into effect within 36 hours of admission.
2. Treatment plans for all other services shall be developed and put into effect within 30 days of admission.

B. Treatment planning shall be conducted by or under the supervision of a physician, psychiatrist, psychologist, or behavioral health professional.

C. The agency shall include the client and, if applicable, the client's parent, guardian or designated representative, and case manager in the development of the treatment plan and treatment plan reviews.
1. If a client, a parent, guardian, or designated representative is unable or unwilling to participate in the planning, or such participation is clinically inappropriate, such circumstances shall be documented in writing and filed in the client record.
2. The client's consent for a course of treatment specified in the treatment plan or updates shall be verified by the dated signature of the client and, if applicable, the client's parent, guardian, or designated representative.

D. The treatment plan shall contain goals that the client is to achieve for improvement or maintenance of behavioral health or adaptive functioning.

E. The treatment plan shall contain specific objectives that relate to the goals and dates when achievement of the objective is expected.

F. The treatment plan shall describe the services, activities and programs planned for the client.

G. The methods used in carrying out the treatment plan shall be appropriate to the client's needs as indicated in the initial or update evaluation.

H. Services provided to the client shall be directed toward carrying out the treatment plan and verified by documentation through progress notes, attendance records, post-tests and performance indicators.

I. The treatment plan shall be reviewed and updated by assigned staff when goals or objectives are accomplished, when additional client deficits that need intervention are identified, but no less than every 90 days with the following exceptions:
1. Detoxification treatment plans shall be reviewed no less than on a weekly basis;
2. Hospital, special hospital units, and psychiatric acute care treatment plans shall be reviewed at least every 15 days;
3. Level I residential treatment plans shall be reviewed at least every 30 days;
4. Outpatient treatment, if intervals of 30 days or longer between client contacts with the agency are part of an approved treatment plan, shall be reviewed a minimum of every 180 days.

J. The written review shall indicate:
1. Methods or services contained in the treatment plan which were not provided by the agency,
2. Progress toward the treatment plan objectives,
3. Issues which impeded treatment progress and whether such issues were client-based or agency-based,

4. Decision to continue or modify the treatment plan or to discontinue services.

K. Within 15 calendar days of the client's discharge from the agency, a summary of treatment plan accomplishments and those areas in need of further services shall be developed and filed in the client record.

Historical Note

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R9-20-405. Requirements for Client Recordkeeping

A. General requirements for client recordkeeping:
1. There shall be written policies and procedures that govern the compilation, locked storage, confidentiality and dissemination of individual client records and client identifying information which address the requirements of this Article.
2. If the client is under 18 years of age, the client record shall include a consent for treatment which is signed by the client's parent or guardian.
3. The client shall have an individual record of treatment services provided by the agency.
4. The agency shall maintain client records as follows:
   a. In one central location within the agency and available for inspection by the Department;
   b. With up-to-date entries, without error, and legible;
   c. With notations and progress notes written in ink, typewritten or computer-printed records, and signed with original signatures; and
   d. Without photocopies, such as, group therapy summaries addressing events that occurred in sessions.
5. Client records shall contain information relating only to the individual client's course of care and treatment. The behavior, comments or actions of any other client who is receiving services from the agency shall not be recorded in another client's record, except for such information that directly affects the care and treatment of the client. If such exceptions are made, other clients who are not relatives of the client shall not be identified in the client record by name or number.
6. There shall be a system of identification, organization and filing of client records to ensure information is maintained properly and for rapid location and retrieval of information at all times.
7. Complete client records shall be retained for five years following discharge. Vital statistics including name, address, date of birth, client identification number, social security number, dates of admission and discharge, reason for discharge, and prognosis shall be retained for ten years. Records on minors shall be maintained for a minimum of five years and for a period not less than three years following the client's 18th birthday.
8. Disposal of client records shall be designed to ensure the confidentiality of information in the record.
9. Information contained in client records shall be kept confidential pursuant to the requirements of A.R.S. § 36-509 for mental health records and federal requirements specified in 42 CFR 2.1 et seq., October 1, 1992, which is incorporated herein by reference and on file in the Office of the Secretary of State, for substance abuse client records.
10. Release of information forms shall indicate the person or agency to receive the information, the specific information to be released, and the expiration date of the release, and shall be signed by the client or the client's guardian. Such forms shall be filed in the client's record along with a copy of information released.
11. Agencies may charge a copying fee to cover the actual cost of copies made in response to a signed, dated release of information.
12. Department staff shall have the right to review client records for the purposes of administering these rules or other state or federal law or regulations.

B. The licensed agency providing case management services shall maintain a master client file which shall include copies of the following:
1. Identifying information as specified in R9-20-406.
2. All documents generated as a result of the client's assessment, evaluation and diagnosis.
3. Master service plan and updates prepared by the clinical case management team with overall goals and objectives for the client.
4. Treatment or staffing summaries prepared by all involved behavioral health service agencies.
5. Notations regarding the case management service provided.
6. Notation of contacts.
7. Documentation of approval for services, or waiting list status, if applicable; and
8. Discharge summaries from agencies where the client has received treatment.

C. The licensed agency providing case management and direct services shall maintain a client file which shall include copies of the following:
1. Identifying information as specified in R9-20-406.
2. Documents generated as a result of the client's assessment, evaluation and diagnosis.
3. Progress notes generated by case managers or treatment staff within the case management agency which reflect therapeutic activities and interventions conducted with the client.
4. The master treatment plan, or part thereof, that is the responsibility of the agency providing case management or direct services.
5. Treatment or staffing summaries prepared by the staff.
6. Notation of contacts.
7. Documentation of approval and authorizations for services, or waiting list status, if applicable; and
8. Discharge summaries from the agency.

D. If client services are provided in a satellite office, the licensed agency shall have written policies and procedures that govern the confidentiality, storage and transportation of individual client records and client-identifying information dissemination.

Historical Note

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R9-20-406. Client Records for Non-emergency Services

A. The client record for non-emergency services shall contain:
1. Identifying information including name, address, telephone number, date of birth, person to notify in case of emergency, client's legal status, referral source, case manager, attending or personal physician, admission date and agency staff member assigned to the client;
2. Client assessments as specified in R9-20-402;
3. Documentation of receipt of client rights information and, if the client is receiving behavioral health services, a consent for treatment form, both documents signed and dated by the client, parent, guardian, or designated representative, if applicable;
4. Copies of any consultation reports or evaluations conducted by other agencies, clinical case management teams or physicians which resulted in admission to the agency or are relevant to treatment and services to be provided by the agency;
5. Referral source summary, if applicable, including the reason for referral, presenting problem and current medications and dosage at the time of referral;
6. Treatment plan which meets requirements of R9-20-404, prepared by assigned staff of the agency.
7. Documentation of periodic assessments of any changes or updates made to the treatment plan pursuant to R9-20-404;
8. Progress notes which document services provided to the client in accordance with the individual treatment plan and progress made toward goals and objectives. Progress notes shall be entered into the client record at the following intervals:
   a. Level I behavioral health facilities - During each shift of the day for the first seven days following admission and daily thereafter. Special notations shall be made. Documentation of any occurrences of restrictive behavior management shall comply with requirements of R9-20-603.
   b. Levels II and III behavioral health facilities - Daily documentation for the first seven days following admission and summaries of progress toward treatment goals every seven days thereafter. Special notations shall be made.
   c. Partial day treatment - Daily documentation for the first seven days following admission and summaries of progress toward treatment goals every seven days thereafter. Special notations shall be made.
   d. Emergency/crisis behavioral health services, outpatient treatment, outpatient rehabilitation and case management - Notation after every treatment session or visit. Special notations shall be made.
   e. Hospital-based programs - Notations as required for hospital licensure.
9. Reports of alleged abuse, accidents, violations of client's rights, psychiatric emergencies, seizures or illnesses occurring while the client is on the agency's premises or engaged in agency activities and treatment shall be fully documented in the client record.
10. A record of written, signed and dated physician orders and verbal orders given by telephone with documentation that such orders were reviewed and signed by the physician in accordance with the agency's policies.
11. A record of all medications administered by licensed medical staff of the agency and any medications self-administered by the client but monitored by agency staff.
12. Notations of communications pertinent to the client's well-being or treatment.
13. Treatment or discharge summary, within 15 calendar days of termination of services which includes:
    a. A summary of services provided;
    b. Accomplishments relating to the treatment plan;
    c. Length of time services were received;
    d. Initial issues disclosed during the assessments, evaluation and diagnosis, and those disclosed during treatment and entered into the service plan which were not resolved;
    e. Recommendations for continuing treatment;
    f. Reason for discharge/termination of services; and
    g. Referrals made.

B. Supplemental client record requirements.
1. Level I, II and III behavioral health facilities and hospitals shall have documentation of a physical assessment within 72 hours or a written report from the client's attending or personal physician documenting the results of a physical examination conducted within 45 days prior to admission.
2. Level I, II and III behavioral health facilities and hospitals shall have documentation of all contacts with, and treatment rendered by, medical, dental or other services.
3. Level I behavioral health facilities and hospitals which provide restrictive behavior management services shall meet additional client record requirements specified in R9-20-603.
4. Level I, II and III behavioral health facilities, hospitals and partial day treatment agencies shall have a record of any dietary modifications or special nutritional requirements.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency error in subsection (A)(8)(a) corrected pursuant to letter received in the Office of the Secretary of State October 8, 1993 (Supp. 93-4).

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R9-20-407. Client Record Requirements for Emergency Services

A. The record for emergency services provided by telephone by a licensed behavioral health service agency shall include, at a minimum:
1. Identifying information relating to the client or information relating to the individual making the contact,
2. Description of behavior and other clinical data,
3. Response of the staff member taking the emergency call,
4. Record of recommendation made,
5. Specific instructions given for the client, and
6. Provisions for follow-up.

B. The record for emergency services provided by a licensed behavioral health service agency shall include:
1. Identifying information including the client's legal status;
2. The time of arrival and the time of discharge;
3. Means of transportation to the emergency service;
4. History including emergency care given prior to the arrival at the agency;
5. Description of behavior precipitating the emergency and other significant clinical data;
6. Results of any assessment conducted;
7. Initial treatment plan if behavioral health services are to be continued at the agency;
8. The condition of the client at the time of transfer or discharge;
9. Disposition, including instructions given to the client about necessary follow-up care. Documentation that oral instructions given to the client upon discharge from the emergency service were also provided to the client in writing and were signed and dated by the client and, if applicable, the client's parent, guardian, or designated representative, if applicable, and the staff member assigned to the client's case.

C. The record of emergency service provided shall be incorporated into the client's record if such record exists.

Historical Note

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R9-20-408. Medication Control

A. Agencies licensed pursuant to this Chapter and providing services to SMI clients shall comply with the requirements stated in A.A.C. Title 9, Chapter 21, Article 2 in addition to this rule.

B. When medications are provided in behavioral health services agencies licensed as crisis stabilization shelters, shelters, and halfway houses, the agency shall comply with this subsection and subsections (D) and (E) of this rule:
1. Adopt written policies which are acceptable to the Department regarding the administration of all medications;
2. Administer medication only by trained personnel and only with a written or verbal order by a licensed physician;
3. Ensure that medication shall only be used for the client for whom it is prescribed.
4. Record and report medication errors and reactions immediately to medical personnel and to the agency administrator or the administrator's designee.
5. Ensure that medication errors and reactions be evaluated by medical personnel and the agency administrator or designee, and action taken shall be documented.
6. Ensure that each client receiving medication be monitored by the client's primary physician.
7. Maintain a log of all medications administered.

C. Medication monitoring and administration by licensed medical staff in facilities not covered by subsection (B) above:
1. Medication monitoring shall be provided by an individual holding a current Arizona license pursuant to A.R.S. Title 32 as a nurse practitioner, physician assistant, physician or registered nurse.
2. Medications shall be administered only by an individual holding a current Arizona license pursuant to A.R.S. Title 32 as a nurse, nurse practitioner, physician assistant or physician.
3. Medications shall only be administered if prescribed by a physician, physician assistant or nurse practitioner currently licensed in Arizona and authorized to prescribe medications.
4. Staff of licensed behavioral health service agencies shall assist clients in obtaining needed pharmaceutical services.
5. The agency shall put into effect policies governing the administration of medications which shall include the:
   a. Methods of administration,
   b. Transcribing of physician orders,
   c. Disposal of discontinued or expired medications, and
   d. Control of stock drugs.
6. Medication orders shall be written only by persons authorized by law to do so. Verbal or telephone orders shall be taken and recorded only by a staff member licensed to do so. These orders shall be co-signed within 48 hours by the authorizing person according to agency policy.
7. The agency shall maintain a medication record for both prescription and over-the-counter medications administered to any client. These records shall be a permanent part of the client's record and shall identify the medications, the dosage, route of administration, times of administration, the name of the physician or other authorized person who ordered the medication, the signature of the staff member administering the medications, and staff observations of the client taking medications.
8. A record shall be maintained which lists on a separate sheet for every type of Schedule II and III drug the following information: date and quantity received, the signature of the nurse accepting delivery, date and time of administration, name of client, dosage administered, the name of the physician who ordered the drug for the client, the signature of staff member administering the dose, and the balance remaining in the prescription container.
9. Adverse drug reactions and medication errors shall be reported immediately to the attending physician and recorded in the client record.
10. If psychotropic drugs are used as a part of restrictive behavior management by Level I behavioral health facili-

ties or hospitals, medication administration shall comply with this subsection and A.R.S. § 36-513.

D. Self-administration of medications:
1. Self-administration of medications is not permitted unless ordered by the client's attending physician or unless performed in a predischarge training program under the supervision of a licensed nurse.
2. Medications may be self-administered at a licensed behavioral health service agency only when there are written policies governing the handling of these medications. The agency shall ensure the availability of a staff member on site at all times when clients are present, who has been trained by the agency to monitor clients when taking medications.
3. Self-administration of injectable medications such as insulin for a diabetic client shall be allowed only under the following conditions:
   a. The client's physician of record has given written orders authorizing the agency staff to allow such administration of the injectable,
   b. The client has been trained to self-administer injections and has demonstrated such capability to agency staff, and
   c. Self-administration of the injectable medication is not contraindicated in the client's treatment plan or by the client's current behavioral health issues.
4. Adverse drug reactions and medication errors shall be reported immediately to the attending physician and recorded in the client's record. An incident report shall also be completed according to the agency's policies and procedures.
5. Agency medication policies and procedures shall include:
   a. Storage of medications,
   b. Method of monitoring the client's self-administration of medication and adverse reactions to such medication,
   c. Method of ensuring that a client who self-administers medication takes only medication prescribed for that client,
   d. Informing a client when medications should be taken,
   e. Method of teaching the client about the expected results and reactions of the medications they are taking, and
   f. Disposal of discontinued medications.
6. Current drug information shall be maintained at the agency to enable staff members responsible for monitoring a client's self-administration of medications to educate themselves about common reactions and side effects of the medication.
7. Self-administered medications shall be kept in the original, labeled prescription container as approved by the State Board of Pharmacy which specifies:
   a. The client's name,
   b. The name of the medication,
   c. The dose,
   d. How often and how long the medication is to be taken, and
   e. The physician's name and prescription date.
8. Self-administration medication records shall be kept in the client's file for all medications taken by the client. These records shall be initialed by the staff member responsible for monitoring a client's self-administration of medication and the client after he takes the medication. The name of the medication taken, the dosage and the time when the medication was taken shall be documented by the client or staff member.

E. Medication storage area:
1. Except for unit dosages, the client's medications shall be stored in the original prescription container, in a separate storage space.
2. All medications shall be kept in locked storage, free from dampness and abnormal temperatures, except for those requiring refrigeration. Only authorized staff members shall have access to the key.
3. Medications requiring refrigeration shall be kept in a separate locked box securely fastened within the refrigerator, unless the refrigerator is locked or is located in a locked medication room. The temperature of the refrigerator shall not exceed 455 Fahrenheit.
4. Medications for external use, and eye, ear and rectal medications shall be stored separately from other medications.
5. Medications having exceeded their expiration date, those which are unusable or not to be released to the client upon discharge and those with an illegible or missing label shall be separated and discarded.
6. The agency shall dispose of all medications in accordance with state and federal requirements. Disposal shall be conducted by a licensed pharmacist or by an authorized staff member in accordance with agency policies and procedures.
7. The agency shall designate a staff member to conduct inspections of all medication storage areas every three months. The inspections shall be documented and verify compliance with all medication storage area requirements of this rule.

Historical Note

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R9-20-409. Initial Emergency Care

A. The agency shall develop and implement a safety education program including procedures to be taken for the care of clients in cases of fire, local disasters, medical or psychiatric emergencies, or other emergency situations.

B. A first-aid kit shall be kept in the licensed behavioral health service agency and accessible to all personnel but out of reach of clients.

C. A list of emergency program numbers and poison centers numbers shall be maintained by a telephone for easy access by all staff.

D. The agency shall develop and implement policies and procedures to manage ill clients.

E. The agency shall notify the client and, if applicable, the client's parent, guardian, or designated representative if the client has been exposed to a contagious disease or infestation immediately upon discovery of exposure. In addition, the agency shall notify the local health department of all reportable diseases.

Historical Note

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R9-20-410. Supplemental Requirements for Agencies Providing Services to Children

A. Agency personnel shall not release a child to anyone other than the custodial parent or agency, guardian or a person designated by documented authorization from the custodial parent, agency or guardian. There shall be a procedure to verify telephone authorizations initiated by the custodial parent or guardian.

B. The agency shall only allow personnel certified by the Department pursuant to A.R.S. § 36-425.03 and R9-20-305 to provide services directly to children.

C. Agency personnel shall not at any time endanger the health or safety of the children under their care.

D. Educational materials, equipment and toys shall be available for all children receiving services in behavioral health service agencies providing partial care or residential treatment. Such items, in a variety of sizes and designs appropriate to the children's developmental and psychological needs, shall be provided for both indoor and outdoor activities.

E. In behavioral health service agencies providing partial care or residential treatment, play materials and sports equipment shall be available in amounts that allow every child to be involved in play or recreational activity at any one time.

F. All equipment, toys and materials shall be maintained in a usable condition and disinfected as necessary.

G. Activities to promote socially accepted behavior and compliance with agency policies and procedures shall not be detrimental to the health, emotional or psychological needs of the child. Personnel shall not humiliate or frighten a child or use corporal punishment and shall not permit other personnel to do so.

H. Activities to promote socially accepted behavior and compliance with agency policies and procedures shall not be associated with eating, sleeping, or toileting.

I. Agency personnel shall use behavior management methods to teach children acceptable behavior. Children shall not be allowed to punish other children.

J. Agencies which are currently licensed by DES as group care agencies shall be exempt from inspection by the Department for compliance with R9-20-501 through R9-20-504.

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R9-20-411. Food Services

A. When food services are provided by a third party, the provider shall meet all conditions stated in this rule. There shall be a formal contract between the agency and the provider containing assurances that the provider will meet all food service and dietary standards imposed by this rule. Current sanitation reports, food service establishment inspection reports, and any contract with third-party food providers shall be on file in the agency.

B. Purchase records of food and related items must be maintained in the facility for 60 days from the date of purchase.

C. Food preparation, storage, and handling shall comply with A.A.C. Title 9, Chapter 8, Article 1 and local ordinances.

D. Staff requirements for food services.

1. The agency or food service organization shall be responsible for the supervision of food service staff.
2. All personnel shall wear clean garments and keep their hands clean at all times while engaged in preparing or serving food and drink.
3. Personnel and clients engaged in the preparation and service of food shall use effective restraints to keep hair from food and contact surfaces.
4. No person having a communicable disease in the transmittable stage, or who is a carrier of organisms that may cause a communicable disease, shall prepare or serve food for others.
5. Duty assignments shall be posted in the kitchen area of agencies having three or more food service staff.

E. Diet and nutrition requirements.

1. The agency shall have policies and procedures to assure proper nutritional care of its clients, whether the food is prepared by clients, staff or a third party.
2. The agency shall not serve the same menu to the same clients twice in one day.
3. Foods shall be prepared in a manner to maintain nutrients, proper temperature, flavor, texture and appearance.
4. Menus shall specify foods to be served and shall be planned a minimum of one week in advance of the meal, dated and posted where easily viewed by all clients, corrected if changed prior to serving, and kept on file for six months.
5. The agency shall serve foods which meet the following standards:
   a. Age-appropriate nutrition requirements shall be met for all clients at the agency.
   b. A variety of foods served within each food group shall be provided every day.

c. Foods served shall adhere to current dietary recommendations for sugar, salt and fat intake.
d. Minimum meal components and serving sizes to meet calorie and nutrient requirements for various age groups shall be determined using standards established by the National Research Council Recommended Daily Allowances (RDA).
e. The use of home canned foods and hunter game meat not approved by the Arizona Game and Fish Department is prohibited.
f. Client food preferences, habits and activities shall be considered in planning menus.

6. If a client requires a modified diet, the agency shall inform food service personnel of the diet restrictions and serve food that complies with the prescribed dietary regimen. Therapeutic diets shall be prepared and served as prescribed.
7. Second servings of nutritious foods shall be made available to all clients over and above the required daily minimums if not contraindicated in the client's individualized service plan.

F. Food preparation, sanitation and storage.
1. Meals shall be provided at routine meal times set by the agency.
2. Food shall be served attractively and at safe temperatures.
3. All food and drink shall be clean and free from spoilage.
4. Foods shall be prepared as close to serving time as possible to protect clients and agency personnel from foodborne illnesses.
5. The agency shall maintain a one-day supply of perishables and a three-day supply of staples adequate to feed all clients and staff in an emergency situation.
6. Eating utensils shall be on hand.
7. Schedules for cleaning of equipment, storage and work areas shall be in writing and kept on file for one month.
8. Reports of sanitation inspections shall be kept on file, showing corrections of all deficiencies.
9. After each use, all non-disposable eating and drinking utensils shall be cleansed with hot water and a detergent, rinsed free of solution and sanitized.
10. All food and drink at risk of spoilage shall be kept at or below 45° F., or above 140° F., except when being prepared or served.
11. Every refrigerator or freezer used for storage of perishable foods shall be provided with a working thermometer located toward the front side of the refrigerator or freezer so that the temperature can be easily and readily observed.
12. Freezers should be kept at or below 0° F.
13. The kitchen and food preparation area shall be lighted, ventilated and located apart from areas which could cause food contamination. All doors and windows in the kitchen and food preparation areas that open to the outside shall be fitted with insect screens.
14. The floors, walls, shelves, tables, utensils and equipment in all rooms where food and drink is stored, prepared or served or where utensils are washed shall be kept free of dirt and in good repair. Stored food shall be protected from insects, rodents and other contamination.

G. Licensed behavioral health service agencies which provide residential services for ten or fewer clients may utilize a family-type kitchen for food preparation, provided the requirements of subsection (F) are met.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency error in subsection (F)(6) corrected pursuant to letter received in the Office of the Secretary of State October 8, 1993 (Supp. 93-4).

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R9-20-412. Pets and Domestic Animals

A. Every licensed behavioral health service agency that allows pets or other animals on the premises shall have policies and procedures regarding the care and maintenance of the animals.
1. The agency administrator shall be responsible to ensure the cleanliness of pets or animals allowed on the agency premises and the animal quarters.
2. Dogs, cats or other domestic animals shall be confined to ensure proper sanitation of the premises and that animals are not a hazard to any clients, staff members or visitors.
3. Maintenance and licensing of animals shall be consistent with local ordinances.

B. Pets shall not be allowed in the kitchen or food service area.

C. All dogs, cats or other animals, owned or under the supervision of the agency or clients, shall be properly vaccinated. For dogs, this includes rabies, leptospirosis, distemper, hepatitis and parvo. Cats shall be vaccinated against rabies and feline leukemia. Documentation of such vaccinations or preventive measures shall be available at the agency for review by Department staff.

D. Wild, dangerous or ill animals are prohibited on the agency premises.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-413. Outings and Transportation

A. For every outing which is not a part of the daily routine, such as a recreational trip of four hours or more or for outings where emergency medical services cannot respond within 12 minutes, a record shall be kept at the agency which includes:
1. A list of clients participating in the outing;
2. Anticipated departure and return times;
3. License plate numbers of every vehicle used for the outing; and

4. Name, location, and, when possible, telephone number of the destination.

B. Emergency information records shall be available in the transport vehicle for every client participating in the outing as well as information regarding each client's medication requirements and any adverse reactions which may be anticipated to occur as a result of the weather, client anxiety, delay in administration of medications or other reasons.

C. If the agency provides vehicular transportation directly, through a contract with a private transport provider, or use of volunteer-driven vehicles, the following requirements shall be met:

1. Vehicular and driver requirements.
   a. The vehicle shall be maintained in a mechanically safe condition.
   b. The vehicle driver shall be 21 years of age or older and hold a current driver's license.
   c. No client shall be transported in portions of vehicles not constructed for the purpose of transporting people such as truck beds, campers, or any trailered attachment to a motor vehicle.
   d. Every client shall be seated on a seat which is securely fastened to the body of the vehicle and which provides enough space for the client's body.
   e. The driver and every passenger shall comply with A.R.S. §§ 28-907 and 28-909 in the use of seat belts.
   f. Agency clients and staff shall not stand or sit on the floor while the vehicle is in motion.
   g. Every vehicle used to transport clients shall have adequate heating and air conditioning.
   h. A first-aid kit and enough drinking water for all clients on the outing shall be maintained in the vehicle used if the outing is planned to last four or more hours.
   i. Agencies shall maintain on file records of all services and repairs for owned or leased vehicles for as long as the vehicle is used by the agency.
2. Transport insurance requirements.
   a. The agency, its transportation contractor, or agency personnel who use personal vehicles to transport clients shall obtain and maintain motor vehicle insurance coverage in accordance with A.R.S § 28-1102 et seq., Uniform Motor Vehicle Safety Responsibility Act.
   b. Proof of insurance shall be kept at the agency and in every insured vehicle.
3. Transport safety requirements.
   a. A copy of emergency medical care information for every client being transported shall be present in the vehicle.
   b. Headphones or earphones shall not be worn by the driver of any vehicle transporting clients.
   c. Vehicle doors shall remain locked at all times when the vehicle is in motion.
   d. The vehicle driver shall remove the keys from the vehicle and set the emergency brake before exiting the vehicle.
   e. A client shall not be left unattended in a vehicle if the client is a child, is considered to be in crisis or unstable, or is functioning at a level which would impair the client's ability to leave the vehicle independently in an emergency situation.
   f. The agency shall provide a safe vehicle-loading and unloading area for all clients which is located in an area away from moving traffic and hazardous obstructions. When away from the agency, the vehicle shall be parked at curbside whenever possible to load and unload a client.
   g. The agency shall notify the OBHL, pursuant to R9-20-111, of any traffic accident involving any client being transported by the agency, its transport contractor or agency personnel utilizing personal vehicles, if any injury occurred which required medical attention.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

ARTICLE 5. ENVIRONMENT; PHYSICAL PLANT; SWIMMING POOLS

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-501. Agency Environment

A. A licensed behavioral health service agency may be located in manufactured housing with a permanent foundation and incapable of being transported from one location to another.

B. Agencies shall be kept clean, in good repair, and free of hazards such as cracks in floors, walks, or ceilings; warped or loose boards, tile, linoleum, hand rails or railings; broken window panes; and any similar type hazard.

C. The interior and exterior of the building shall be painted, stained, or maintained so as to protect the health and safety of clients. Loose, cracked, or peeling wallpaper or paint shall be replaced or repaired.

D. All furniture and furnishings shall be maintained free from dirt, in good repair and shall contribute to creating a therapeutic environment.

E. The agency shall be accessible to handicapped persons or it shall provide alternative access to necessary services.

F. The agency shall have designated space for private interviewing, evaluating, examining or treating and a waiting area for clients and their visitors and other therapeutic activities included in the agency program description.

G. Toilets and lavatories shall be available to the agency's clients, staff and visitors during activity hours and provide privacy unless contraindicated by treatment policies and procedures and indicated in the agency program description.

H. All areas of the agency occupied by clients shall be climatically controlled in a manner conducive to the comfort and privacy of the clients.

1. A temperature of not less than 70° F. shall be maintained during waking hours in all areas used by clients. During hours when clients are normally asleep, a temperature of not less than 65° F. shall be maintained. These temperature requirements apply unless otherwise mandated by federal or state authorities.
2. Temperatures of all inside areas of buildings used by clients shall not exceed 85° F.

I. Drinking water shall be readily available and easily accessible to clients.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-502. Indoor Environmental Requirements for Level I, II, and III Behavioral Health Facilities

A. In addition to the requirements specified in R9-20-501, every Level I, II, or III behavioral health facility shall make available indoor activity areas which accommodate:
1. Social and recreational activities,
2. Private conversations,
3. Group activities, and
4. Client privacy when appropriate.

B. Mirrors free of distortion shall be placed in places to aid in grooming and to enhance self-awareness.

C. Clocks and calendars shall be provided to promote awareness of time and day.

D. A telephone which allows clients to conduct private conversations shall be available in accordance with agency policies and accessible within the agency.

E. Agency lighting shall promote clear perceptions of people and functions, activities and reading. When and where appropriate, lighting shall be controlled by clients.

F. Clean, lighted and ventilated laundering facilities for client use shall be available on the premises or in the immediate neighborhood.

G. Books, magazines, newspapers, arts and crafts materials, radios and televisions shall be available in accordance with all clients' educational, cultural, and recreational backgrounds, age and needs.

H. Bedrooms shall meet the following requirements:
1. All client bedrooms shall be ventilated, lighted and located convenient to a bathroom.
2. Client bedrooms designated for single occupancy shall provide a minimum inside measurement of 80 square feet of usable floor space.
3. Client bedrooms designated for multiple occupancy shall provide a minimum inside measurement of 50 square feet of usable floor space per bed, have a minimum of 3 feet between beds and be limited to four occupants for behavioral health residential facilities that are licensed pursuant to this Chapter and provide services to clients who are 17 years of age and younger or SMI clients who are subject to the provisions of A.A.C. Title 9, Chapter 21. Behavioral health residential facilities that provide services to clients 18 years of age and older and which are currently licensed by the Department have until October 1, 1998, to comply with the occupancy limitation requirements of subsection (H)(3) of this Section.
4. Bedrooms shall be constructed and furnished to allow unimpeded access to exit doors and passageways from all client-occupied parts of the room.
5. Bedroom furnishings shall be arranged to allow for unobstructed opening of storage drawers, closets and exit doors.
6. All client bedrooms shall open directly into a corridor, a common use area or the outside. No bedroom shall be used as a passageway to another room, bath, or toilet unless that room, bath or toilet is for the exclusive use of those occupying the bedroom.
7. The client bedroom shall be furnished with, at a minimum, the following equipment per client:
   a. Individual storage space such as dressers, chests, or wardrobes;
   b. A bedside table or equivalent;
   c. Closet space for hanging clothes;
   d. A bed in good repair with a mattress that is free of dirt, odors, stains, rips, tears or lumpy stuffing and is not less than 36 inches in width and 72 inches in length, with the top surface of the mattress at a comfortable height to ensure easy access by clients. Cribs shall be acceptable for persons under three years of age.
   e. A supply of bedding appropriate to the seasons, including a mattress cover, pillow, pillow case, sheets, blankets and spread enough to allow changing of bed linen as necessary to keep beds dry and free of odors and dirt. No less than two clean bed sheets and a pillow case shall be provided to each client every seven days.
   f. The placement of a client in a bedroom shall be according to age, developmental levels, clinical needs and needs for group support, privacy or independence.
   g. Every client shall be allowed to keep and display personal belongings and to add personal touches to the decoration of the client's rooms. The agency shall have written policies to govern decorative displays.
   h. Every client will be provided a place in which personal belongings may be securely stored.
   i. Bedrooms shall have windows which open to the outside, unless contraindicated for the clients occupying the room.

I. Bathrooms shall meet the following requirements:
1. A toilet and lavatory facilities of easily cleanable construction shall be provided for every six clients, and toilets shall be equipped with seats.
2. A minimum of one tub or shower, equipped with nonslip devices, and of cleanable construction shall be provided for every eight clients.
3. Bathrooms shall be ventilated, lighted and have clearly labeled hot and cold running water.
4. Every bathroom shall have a door in working order to ensure privacy, unless contraindicated by treatment policies and procedures and included in the agency program statement.
5. There shall be enough hot water for all clients to bathe every 24 hours and to carry out laundry, dishwashing, and sanitation functions.

J. Dining area requirements:
1. Dining rooms in behavioral health service agencies providing residential treatment or care shall be supervised and staffed to provide assistance to clients when needed and to ensure that each client receives each meal.

2. The dining area shall be lighted, ventilated, and furnished.
3. The dining area shall not be used as a sleeping area for clients or staff.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency error in subsection (J)(1) corrected pursuant to letter received in the Office of the Secretary of State October 19, 1993 (Supp. 93-4).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-503. Environmental Cleanliness and Sanitation for Level I, II, and III Behavioral Health Facilities

A. Odors shall be controlled by sanitation practices, effective cleaning procedures, and proper use of ventilation.

B. The agency shall be free of unsafe or unsightly clutter, or accumulations of possessions, equipment or supplies.

C. Bedding shall be kept free of odors, stains or dirt.
1. Mattresses and pillows both shall be sanitized between uses by different clients.
2. Blankets and bedspreads shall be washed or dry cleaned no less than every three months.
3. Bed linens shall be washed no less than every seven days, or more frequently if necessary.

D. All trash, garbage and rubbish from residential areas shall be collected every 24 hours and taken to storage facilities.
1. Garbage shall be removed from storage facilities frequently enough to prevent a potential health hazard or, at a minimum, twice every seven days.
2. Wet garbage shall be collected and stored in waterproof, leakproof containers pending disposal.
3. All containers, storage areas and surrounding premises shall be kept clean and free of insects, rodents and dirt.
4. If public or contract garbage collection services are available, the agency shall subscribe to these services unless the volume makes on-site disposal feasible.
5. If garbage and trash are disposed of on premises, the method of disposal shall not create nuisance conditions.

E. The agency shall be free of insects and rodents. Documentation of pest control measures including any chemicals used and the frequency of use shall be available for review by the Department.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-504. Supplemental Requirements for Outdoor Areas of Level I, II, and III Behavioral Health Facilities

Outdoor activity areas shall have no less than 75 square feet per client for recreational and relaxation activities and shall meet the following requirements:
1. Outdoor activity space shall have both sunny and shaded areas.
2. Any construction or equipment which constitutes a safety hazard shall be fenced or enclosed.
3. Outside structures and recreational equipment shall be maintained and arranged to minimize hazard from conflicting activities.
4. Outdoor recreational areas shall kept free of litter and trash and standing water.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-505. Physical Plant Standards

A. Level I behavioral health facilities providing detoxification services licensed prior to the adoption of these rules shall comply with the requirements for "Existing Health Care Occupancies" as identified in Chapter 13 of the "Life Safety Code" adopted by reference in A.A.C. R9-1-412(B).

B. Level I behavioral health facilities providing detoxification services licensed after the adoption of these rules shall comply with the requirements of institutional occupancies as identified in A.A.C. R9-1-412. These occupancies shall further comply with the requirements of "Special Hospital, Psychiatric" as identified in A.A.C. R9-10-432.

C. Level I behavioral health facilities providing restrictive behavior management, psychiatric acute care, intensive treatment service agencies licensed prior to the adoption of these rules shall comply with the requirements of "Existing Residential Board and Care Occupancies" as identified in Chapter 23 of the "Life Safety Code" adopted by reference in A.A.C. R9-1-412(B).

D. Level I behavioral health facilities providing restrictive behavioral management, psychiatric acute care, intensive treatment service agencies licensed after the adoption of these rules shall comply with the requirements of "New Residential Board and Care Occupancies" as identified in Chapter 22 of the "Life Safety Code" adopted by reference in A.A.C. R9-1-412(B).

E. All licensed Level II and Level III behavioral health service agencies shall comply with the requirements of "Lodging or Rooming Houses" as identified in Chapter 20 of the "Life Safety Code", adopted by reference in A.A.C. R9-1-412(B).

F. Shelters; Halfway Houses, if not licensed pursuant to Article 7 and 8 of this Chapter, shall comply with the following:
1. Agencies shall be kept clean, in good repair, and free of hazards.
2. The interior and exterior of the building shall be maintained so as to protect the health and safety of clients.
3. All furniture and furnishings shall be maintained free from dirt and in good repair.
4. The agency shall be accessible to handicapped persons or it shall have written policies and procedures that describe how handicapped individuals shall gain access to the agency.
5. Bathrooms shall be available which provide privacy, are easily cleanable construction, and have hot and cold running water.
6. Drinking water shall be readily available.
7. All client bedrooms shall be ventilated, lighted, and located convenient to a bathroom.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-506. Swimming Pools; In Ground or Permanently Installed

A. Swimming pools located on the premises of a licensed behavioral health service agency shall:
1. Conform to manufacturer's specifications for installation and operation and shall be maintained and operated in a safe and sanitary manner at all times.
2. Have a recirculation system, to be run a minimum of 12 hours per day during seasonal use, including a minimum of one removable strainer, two pool inlets placed on opposite sides of pool, one drain located at the pool's lowest point and covered by a grating designed to prevent suction of body surfaces.
3. Have an automatic disinfectant system and a vacuum cleaning system.
4. When chlorination is used, a range of free chlorine tested by orthotolidine method, of 0.4 to 1.0 ppm, as pH range of 7.0 to 8.0, shall be maintained.
   a. Dry or liquid chemical sources may be added directly to pool water only when enough time exists for dispersal before use.
   b. A daily log of chemistry readings and resultant action taken shall be kept at the agency and available for Department inspection.
5. Have a shepherd's crook and one-ring buoy with no less than 25 feet of 1/2 inch rope securely attached.
6. Have life jackets available for clients who cannot swim or have a history of seizure disorder to use while in the swimming pool.
7. Be enclosed by a separate fence with a minimum height of 5 feet with vertical openings not greater than 1 3/4 inches and a self-closing, self-latching, lockable gate. Every gate shall be kept locked whenever the pool is not in use.
8. Be inspected by the local, county or city health department annually. Records of every inspection shall be kept at the agency and available for inspection by the Department.

B. The agency shall provide ratios of personnel to clients, as defined for the specific program type. When more than one client is in the pool, there shall be, at a minimum, two staff members present.

C. A minimum of one staff person currently certified in cardiopulmonary resuscitation must be present in the pool, or observing poolside, for swimming and water activities conducted in a private swimming pool or public swimming pool that does not provide certified, advanced lifesaving staff on the premises.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

ARTICLE 6. LEVEL I BEHAVIORAL HEALTH SERVICE AGENCIES

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-601. Level I General Licensure Requirements

A. In addition to requirements specified in R9-20-101 through R9-20-506, Level I behavioral health facilities shall comply with the requirements of this Article.

B. A Level I behavioral health service facility shall be staffed to acuity. A Level I behavioral health service facility shall provide a medical staff. Nursing services shall be provided on a 24-hour basis in accordance with the Nurse Practice Act unless the agency is accredited by a nationally recognized accreditation organization approved by the Department and the accreditation report has been submitted to the OBHL.

C. If Level I services are provided to clients who are 17 years of age or younger, such clients shall receive services and be housed in a separate unit or separate facilities than the unit serving clients 18 years of age or older excluding those clients as referenced in R9-20-301(I).
1. Children shall not share a sleeping room with any client over age 17;
2. Meals shall be served separately from clients over age 17;
3. Treatment services and program activities shall be provided separately from clients over age 17.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-602. Level I Behavioral Health Facilities Providing Detoxification Services

A. Required detoxification services:
1. A Level I behavioral health facility which provides detoxification services shall state in its program description the types of detoxification services available through the agency.
2. The agency shall maintain a structured treatment setting with 24-hour supervision capable of managing the physiological manifestations and distress for clients who have severe or acute symptoms of withdrawal from chemical dependency.
3. The agency shall have written policies and procedures governing the detoxification process utilized by the agency, overdose management and methodologies to be used in cases of medical emergency.
4. If the client has not had a medical status and assessment completed within the two-hour period immediately prior to the client's arrival, the client's medical status and needs shall be assessed upon arrival at the agency. An assessment and medical status completed within the two previous hours shall be provided to the agency upon the client's arrival. A client shall not be held for more than 12 hours without being admitted or referred to another agency.
5. Chemical dependency and detoxification services shall begin only upon a direct order from a physician defining the medical regimen to be followed. These services shall be available at the agency and shall include the following:
   a. Triage services to determine the need for medical care and transport to a hospital;
   b. Physical examination and chemical dependency assessment within 24 hours of admission;
   c. Close observational assessment and regular monitoring of vital signs;
   d. Nursing services during all hours of operation by licensed nurses in accordance with the Nurse Practice Act;
   e. Counseling, which may include individual, group and family counseling and motivational educational programs;
   f. Activities to involve the client in interpersonal interactions;
   g. Psychiatric or psychological evaluation which shall be available as needed;
   h. Referral to other service components or another appropriate treatment agency upon completion of detoxification.
6. The agency shall also have the capability and qualified staffing pattern to provide emergency care for complications and medical issues associated with chemical dependency such as alcoholic hallucinosis, convulsive seizures, delirium tremens, hepatitis, cirrhosis, pancreatitis, or cardiomyopathy.
7. Current toxicology references, antidotal information and telephone numbers for poison control shall be readily available in the staff or nurse's station.
8. Clients who require treatment for an acute medical condition beyond the scope of the agency shall be transferred and admitted to an inpatient hospital.
9. The agency shall provide, or have access to, transportation to a hospital inpatient unit on an emergency basis. Telephone numbers of ambulance services and other resources to provide transportation shall be available.
10. The agency may provide pharmacological and medication administration services.

M. Minimum staffing requirements:
1. Every Level I behavioral health facility providing detoxification services shall have a physician on-site or on-call at all times, and the availability of the physician shall be documented.
2. Behavioral health personnel providing services to clients withdrawing from chemical dependency shall be knowledgeable of chemical dependency and symptomatology of withdrawal from the range of substances for which the agency provides detoxification. Personnel shall also be knowledgeable of symptoms of complications and medical problems associated with chemical dependency, effects and side effects of medications used in detoxification and procedures such as taking vital signs, observational assessment, changing bedding and assisting clients in bathing and eating activities.
3. The agency shall provide, or make available through contract, other staff to provide services necessary to meet the treatment plan requirements for all clients, including psychiatric and psychological services and specialized counseling services.
4. The agency shall provide, through employment or contract, services of a dietitian to review and approve all special diet menus and, annually, regular daily menus.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-603. Level I Behavioral Health Facilities Providing Restrictive Behavior Management

A. General requirements.
1. Restrictive behavior management techniques shall be authorized only in Level I behavioral health facilities.
2. Use of such techniques by unauthorized agencies shall result in suspension or revocation of a behavioral health license.
3. Level I behavioral health facilities authorized to employ restrictive behavior management practices shall provide, or have available through agreement, ambulance services for transport of a client in psychiatric emergency to a hospital or more secure facility if it becomes necessary.
4. Level I behavioral health facilities shall have equipment and staff available to provide initial care for medical

emergencies or have an agreement with a nearby hospital to provide such care.

B. Policies and Procedures:

1. The agency shall develop and maintain policies and procedures, which incorporate standards set forth in these rules, for the use of restrictive behavior management practices, including locked seclusion, mechanical restraints or the administration of medication.
2. The agency shall not use restrictive behavior management practices as punishment, for the convenience of staff members, or as a substitute for a treatment program. It shall be used only to prevent the client from injuring self or others or to prevent serious disruption of the therapeutic environment.
3. Staff shall immediately notify a supervisor of any psychiatric emergency requiring restrictive behavior management and clear other clients from the immediate area.
4. If the client is dangerous to self or others or to prevent serious disruption of the therapeutic environment, and less restrictive methods of crisis management are not effective, staff may intervene by using restrictive behavior management or lockable seclusion until the crisis is resolved or the client is transported to a secure facility.

C. Treatment provided in locked seclusion.

1. Use of a locked seclusion room shall be initiated only upon the written, dated and signed order from a physician.
   a. If the order is given by telephone, it shall be entered into the client's record and signed and dated by the physician within 24 hours of the telephone call.
   b. Such orders shall be time-limited, shall not exceed 24 hours, and shall not be extended without examination of the client by the physician initiating the extension order.
   c. Standing or PRN orders for locked seclusion shall not be used.
2. Staff shall attempt to verbally convince the client to enter the locked seclusion room voluntarily. If the client refuses to cooperate, a team effort shall be used to safely escort the client to the seclusion room.
3. All items shall be removed from the client which, in the clinical judgement of staff, might be a danger to the client. The use of tobacco products shall not be allowed in a locked seclusion room.
4. Staff shall provide an explanation to the client as to the reason locked seclusion is required, inform the client of the expected behavior necessary to be released, and document such conversation and client response in the client record.
5. When a client is placed in locked seclusion, the staff member in charge of the agency at the time of such seclusion shall be responsible to ensure that the client is observed and findings documented in the client's record a minimum of every 15 minutes. Staff shall not enter the locked seclusion room if it is occupied unless accompanied by another staff member.
6. If the client has a history of seizure activity, the client shall be monitored a minimum of every five minutes.
7. If the client displays seizure activity while in locked seclusion, monitoring staff shall:
   a. Request assistance from additional agency staff trained in the care of clients having seizures;
   b. Provide seizure care;
   c. Immediately bring the client's seizure activity to the attention of the physician who shall complete a clinical assessment of the client's seizure activity and the need to continue locked seclusion; and
   d. Document the incident and resulting actions in the client's record.
8. As deemed necessary, but not less than every hour, staff shall conduct a clinical assessment of the client's behavior and physical condition to determine if the crisis has abated and whether the physician should be notified. Results of the assessment shall be documented in the client record.
9. The client shall be offered fluids and the opportunity to use toilet facilities a minimum of every two hours while in locked seclusion. This shall be documented in the client record.
10. Nutritious meals shall be provided to a client in locked seclusion if mealtimes fall during the time period of seclusion. Staff shall supervise all meals provided to the client while in locked seclusion.
11. Upon abatement of the crisis, and upon clinical assessment that indicates the client is ready for release, staff shall request the physician to discontinue the order for locked seclusion. If the order to discontinue locked seclusion is received by telephone, the order must be signed and dated by the ordering physician within 24 hours.
12. A complete description of the psychiatric emergency shall be immediately entered into the client record and include:
    a. Documentation of the incident;
    b. Staff actions and rationale for the method employed and a description of the client's response to staff actions;
    c. All orders by the physician to utilize restrictive behavior management;
    d. Summary of seclusion check reports every 15 minutes, staff hourly assessments of behavior and physical condition and other required documentation of staff attention while the client was secluded;
    e. The resolution of the psychiatric emergency; and
    f. Any changes to be implemented in the client's treatment plan.
13. Every incident of locked seclusion shall be reviewed at agency staffing or quality assurance meetings. Resulting recommendations for change in policy or procedures shall be forwarded to the agency governing authority for approval and implementation.

D. Treatment provided to clients using mechanical restraints:

1. Use of mechanical restraints shall be initiated only upon written, dated and signed orders from a physician.
   a. If the order is given by telephone, it shall be entered into the client record and signed and dated by the physician within 24 hours.
   b. Such order shall be time limited, shall not exceed 24 hours, and shall not be extended without examination of the client by the physician initiating the extension order.
   c. Standing or PRN orders for mechanical restraint shall not be used.
2. Restraints may be applied when the client is suicidal or a danger to self or others.
3. Staff shall provide an explanation to the client as to the reason physical restraint is required, inform the client of the expected behavior necessary to be released and document such conversation and client response in the client record.

4. Clients in mechanical restraints shall have a staff member assigned each shift to monitor the client for the duration of the time the restraints are in place.
5. If the client displays seizure activity while in mechanical restraints, monitoring staff shall:
   a. Request assistance from additional agency staff trained in care of a seizuring client;
   b. Remove the client from the restraints and provide seizure care;
   c. Immediately bring the client's seizure activity to the attention of the physician who shall complete a clinical assessment of the client's seizure activity and the need to continue the use of mechanical restraints; and
   d. Document incident and resulting actions in the client record.
6. Staff supervising the client in mechanical restraints shall loosen such restraints, one at a time, a minimum of every two hours to provide active range of motion exercises and any required skin care for periods of restraint lasting two hours or more. The procedure shall be documented in the client record.
7. Staff shall assess the client's behavior and physical condition a minimum of every hour that the client is in mechanical restraints. Results of the assessment shall be documented in the client record.
8. The client shall be offered fluids and the opportunity to use toilet facilities a minimum of every two hours while in mechanical restraints. This shall be documented in the client record.
9. Nutritious meals shall be provided to a client in mechanical restraints if mealtimes fall during the time period of restraint. Staff shall supervise all meals provided to the client while in restraints.
10. Upon abatement of the crisis, and upon clinical assessment indicating the client is ready for release, staff shall request a physician to discontinue the mechanical restraint order. If the order to discontinue restraints is received by telephone, the order must be signed and dated by the ordering physician within 24 hours.
11. A complete description of the psychiatric emergency shall be immediately entered into the client record and include:
    a. Documentation of the incident;
    b. Staff actions and rationale for the method employed and a description of the client's response to staff actions;
    c. All orders by the physician to utilize restrictive behavior management;
    d. Summary of one-to-one supervision of the client in restraint, staff hourly assessments of behavior and physical condition and other required documentation of staff attention while the client was in restraints;
    e. The resolution of the psychiatric emergency; and
    f. Any changes to be implemented in the client's treatment plan.
12. Every incident of the use of mechanical restraints shall be reviewed at agency staffing or quality assurance meetings. Resulting recommendations for change in policy or procedures shall be forwarded to the agency governing authority for approval and implementation.
13. A summary of every incident of the use of mechanical restraints which exceeds four hours and which occurs in a Level I behavioral health facility shall be reported to Behavioral Health Services.

E. Staff qualifications and staffing ratio requirements shall provide restrictive behavior management services and comply with requirements of this rule without jeopardizing staffing of the primary program.

F. Physical facility and safety requirements for lockable seclusion rooms.
1. The room to be used for seclusion purposes shall:
   a. Be no less than 64 square feet and located within close proximity of the nurse's station or staff office.
   b. Be furnished with only a bed, bolted to the floor and a fire-retardant mattress.
   c. Be ventilated, kept at a temperature no less than 64° F. and no more than 85° F. Heating and cooling vents shall be out of reach of the client.
   d. Have no electrical outlets or exposed wiring located on any wall or ceiling of the room.
   e. Have walls, floor and ceiling which are solidly and smoothly constructed, to be cleaned easily, and have no rough or jagged portions.
2. The door to the room shall have a shatterproof glass viewing window which is located at a convenient viewing level of staff.
3. Nonbreakable viewing discs may be used to provide a panorama of all areas of the room.
4. Rooms that have a lock which can be opened only from the outside hallway shall have a smooth metal plate on the back of the lock located in the room to stop the client from jamming the lock and thereby creating a fire and safety hazard.
5. Lighting shall be provided to eliminate shadows and allow for the comfort of the client and for staff observation of the entire room.
6. New construction or modification of lockable seclusion rooms shall, at a minimum, meet the requirements set forth in the Life Safety Code, Standard 101, Chapter 14, which is adopted in A.A.C. R9-1-412.
7. Existing lockable seclusion rooms shall, at a minimum, meet the requirements set forth in paragraphs (1) through (5) above, or obtain an approved variance from the Arizona State Fire Marshal.
8. Agencies licensed pursuant to this Chapter and providing services to SMI clients are subject to the provisions of A.A.C. Title 9, Chapter 21.

Historical Note

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R9-20-604. Level I Behavioral Health Facilities Providing Psychiatric Acute Care

A. Required psychiatric acute care services.
1. A Level I behavioral health facility which provides psychiatric acute care shall maintain a highly structured

treatment setting with 24-hour supervision for clients who have severe or acute behavioral health issues.

2. Assessment and evaluation services shall be available at the agency directly or through contract including triage services, psychiatric evaluation, psychological testing, physical examination, medication assessment, laboratory services, pharmacological services and observational assessment.
   a. An agency shall not retain a client for more than 23 hours without being admitted or referred to another agency.
   b. A physical examination and psychiatric evaluation shall be provided within 24 hours of admission.
   c. Medical orders shall be implemented and medications shall be administered to the client only upon direct order from a physician, physician assistant or nurse practitioner.
3. The agency shall have the capability and qualified staffing pattern to provide:
   a. Emergency reception and initial evaluation;
   b. Medication stabilization services;
   c. Crisis counseling including individual, group and family counseling;
   d. Court-ordered mental health evaluation and treatment;
   e. Activity therapy to involve the client in reality-oriented events and interpersonal interactions;
   f. Restrictive behavior management services; and
   g. Referral to other service components or another appropriate care agency.
4. Prior to the client's discharge, staff shall coordinate with the client's family, friends, employers, designated representative and case manager, as appropriate, to prepare the client for returning to a less restrictive setting.
5. The agency shall have an agreement with a local hospital or, if none are located in the locality of the agency, a hospital in the nearest community, for access to an inpatient unit to assure that referred clients are admitted within 24 hours of referral by the primary physician.
6. Clients who also require treatment for an acute medical condition shall be transferred and admitted to an inpatient hospital or other health care facility.
7. The agency shall provide, or have access to, transportation to a hospital inpatient unit on an emergency basis.
8. The agency shall have written policies and procedures governing treatment activities provided by the agency, overdose management and methodologies to be used in cases of medical emergency or death.

B. Minimum staffing requirements.

1. Every Level I behavioral health facility providing psychiatric acute care shall have a minimum of one psychiatrist who shall be on call 24 hours per day and shall make rounds a minimum of five days per week.
2. Backup coverage may be provided by a licensed physician who shall consult with the psychiatrist.
3. An agency located in a city, town or unincorporated area with a population of less than 100,000 and located 30 miles from a metropolitan area may utilize a licensed physician for on-call activities and daily rounds if the physician has postgraduate training and experience in diagnosis and treatment of behavioral health issues and disorders.
4. The agency shall provide, or make available through contract, adequate qualified staff to provide services necessary to meet the treatment plan requirements for all clients, which may include psychiatric and psychological services, recreational and occupational therapy, educational, vocational and specialized counseling services.
5. The agency shall provide, through employment or contract, services of a dietitian to review and approve annually all special diet menus and regular daily menus.

Historical Note

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R9-20-605. Level I Behavioral Health Facilities Providing Intensive Services

A. Required intensive services.

1. The agency shall provide a structured treatment setting with daily 24-hour supervision for clients who have serious and/or acute behavioral health issues which require intensive therapeutic counseling and activity, intensive staff supervision, support and assistance.
2. Assessment and evaluation services shall be provided by the agency, or through a contract, including psychiatric evaluation, psychological testing, physical examination, medication assessment, laboratory services, pharmacological services, and observational assessment.
   a. Such services should not be repeated upon admission if they have been provided for the client within the prior 45 days or there has not been a break in service delivery for a period greater than three days immediately prior to admission unless clinical indications are documented clearly and in detail in the client record.
   b. Copies of all assessment and evaluation reports shall be used in service planning and filed in the client's record.
3. Therapeutic service shall be provided in accordance with the individualized client treatment plan. Such services provided to children shall include psychosocial rehabilitation but shall not include educational services.
4. Social and recreational activities shall be provided, or a referral of clients to recreational and social activities, during the hours they are not involved in other planned or structured activities. Recreational and social activities shall be planned with client participation and posted in a conspicuous location.
5. Opportunity shall be provided for all clients to participate in religious services and other religious activities within the framework of their individual and family interests.
6. Agencies that provide services to children shall have an education component approved by the Arizona Department of Education, or arrange for the educational needs of the clients through the local school district.
7. Every client, within 24 hours of admission to an agency, shall be provided an orientation which includes, at a minimum, the following:

a. Explaining the agency's services, activities, performance expectations, rules and regulations, including providing to the client written agency rules.
b. Familiarizing the client with the agency's premises and, if not contraindicated, the neighborhood and public transportation systems.
c. Scheduling the client's activities.
d. Explaining client rights and grievance procedures.
e. Introduction to agency personnel and other clients.

8. The agency shall have written policies and procedures governing staff responsibilities and duties in cases of medical or psychiatric emergency or death.

B. Minimum staffing requirements for facilities providing intensive treatment services.

1. The agency shall have the capability and qualified staff to provide intensive counseling and treatment services and, if specified in the agency program description:
   a. Court-ordered mental health treatment,
   b. Restrictive behavior management services,
   c. Other services as defined in the agency program description.
2. The agency shall have available a minimum of one psychiatrist who shall be on call 24 hours per day and shall make rounds as needed.
3. Backup coverage may be provided by a licensed physician who shall consult with the psychiatrist.
4. An agency located in a city, town or unincorporated area with a population of less than 100,000 and located 30 miles from a metropolitan area may utilize a licensed physician for on-call activities and daily rounds if the physician has postgraduate training and experience in diagnosis and treatment of behavioral health issues and disorders.
5. The agency shall be staffed to acuity. If restrictive behavior management practices are used, the agency shall provide additional staffing to meet requirements specified in R9-20-603.
6. The agency shall have enough qualified staff to meet the treatment needs of its clients and provide services described in its program description.
7. The agency shall provide directly or through contract one behavioral health professional for each 20 clients or fraction thereof.
8. The agency shall provide, or make available through contract, adequate qualified staff to meet other requirements of the treatment plan for the agency clients including psychological services, recreational and occupational therapy, educational, vocational and specialized counseling services.
9. The agency shall provide, through employment or contract, services of a dietitian to review and approve all special diet menus and, annually, regular daily menus.

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ARTICLE 7. LEVEL II BEHAVIORAL HEALTH SERVICE AGENCIES

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-701. Level II General Licensure Requirements

A. In addition to requirements specified in R9-20-101 through R9-20-506, Level II behavioral health facilities shall comply with the applicable requirements of this Article.

B. If Level II services are provided for clients who are 17 years of age or younger, such clients shall receive services and be housed in a separate unit or separate facilities than the unit serving clients 18 years of age or older excluding those clients as referenced in R9-20-301(I).

1. Children shall not share a sleeping room with any client over age 17;
2. Meals shall be served separately from clients over age 17;
3. Treatment services and program activities shall be provided separately from clients over age 17.

C. The agency shall have written policies and procedures governing staff responsibilities and duties in cases of medical or psychiatric emergency or death.

Historical Note

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R9-20-702. Level II Behavioral Health Facility Providing Structured Services

A. Services required in a Level II behavioral health facility.

1. A structured treatment setting with daily 24-hour supervision for clients who require extensive therapeutic counseling and activity, staff supervision, training in activities of daily living or support and assistance.
2. Assessment and evaluation services which may be provided by the agency or through a contract, including psychiatric evaluation, psychological testing, physical examination, medication assessment, laboratory services, pharmacological services and observational assessment, if applicable.
   a. Such services shall not be repeated upon admission if they have been provided for the client within the prior 45 days or there has not been a break in service delivery for a period greater than three days immediately prior to admission unless clinical indications are documented clearly and in detail in the client record.
   b. All available assessment and evaluation reports shall be used in service planning and filed in the client's record.

3. Counseling or therapeutic services shall be provided in accordance with the individualized client treatment plan. Such services provided to children shall include psychosocial rehabilitation but shall not include educational services.
4. Agencies that provide extensive residential services to SMI clients shall ensure the availability of a full range of support services, including vocational services, peer support, recreation, daily living and counseling.
5. Social and recreational activities shall be provided, or clients shall be referred to recreational and social activities, during the hours they are not involved in other planned or structured activities. Recreational and social activities shall be planned with client participation and posted in a conspicuous location.
6. Opportunity shall be provided for all clients to participate in religious services and other religious activities within the framework of client and family interests.
7. Orientation shall be provided to every client within 24 hours of admission to an agency and shall include the following:
   a. An explanation of the agency's services, activities, client performance expectations, agency policies and procedures, and agency rules;
   b. An orientation of the agency's premises and, if not contraindicated, the neighborhood and public transportation systems;
   c. A schedule of the client's activities;
   d. An explanation of the client rights and grievance procedures;
   e. A copy of the agency rules and client rights; and
   f. An introduction to agency personnel and other clients.
8. Agencies that provide supervised residential care shall ensure that transportation is available for clients to obtain the required services or treatment specified in the client's individual treatment plan.

B. Minimum staffing requirements for Level II facilities.
1. The agency shall have the capability and qualified staff to provide counseling and treatment services specified in the agency's program description.
2. The agency shall have an agreement or contract with a psychiatrist or physician to provide coverage or on-call consultation and services.
3. The agency shall be staffed to acuity and have qualified staff to meet the treatment needs of its clients and provide services described in its program description.
4. The agency shall provide, directly or through contract, qualified staff to meet other requirements of the treatment plan for all clients which may include psychological services, recreational and occupational therapy, and educational, vocational and specialized counseling services.
5. The agency shall provide, through employment or contract, services of a dietitian to review and approve, annually, all special diet menus and regular daily menus.

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ARTICLE 8. LEVEL III BEHAVIORAL HEALTH SERVICE AGENCIES

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R9-20-801. Level III General Licensure Requirements

A. In addition to requirements specified in R9-20-101 through R9-20-506, Level III behavioral health facilities shall comply with the applicable requirements of this Article.

B. If Level III services are provided for clients who are 17 years of age or younger, such clients shall receive services and be housed in a separate unit or separate facilities than the unit serving clients 18 years of age or older excluding those clients referenced in R9-20-301(I).
1. Children shall not share a sleeping room with any client over age 17;
2. Meals shall be served separately from clients over age 17;
3. Treatment services and program activities shall be provided separately from clients over age 17.

C. The agency shall have written policies and procedures governing staff responsibilities and duties in cases of medical or psychiatric emergency or death.

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R9-20-802. Level III Behavioral Health Facilities Providing Supervised Services

A. Services required in a Level III behavioral health facility:
1. The agency shall provide a safe, healthy and therapeutic environment with daily 24-hour supervision for clients. At a minimum, the agency shall provide supportive, protective oversight or behavior management or psychosocial rehabilitation to assure that clients receive required medications, obtain needed therapeutic services, and have transportation to outside therapeutic services when indicated.
2. The agency may provide directly, or by contract with a licensed qualified provider, necessary assessment and evaluation services including psychiatric evaluation, psychological testing, physical examination, medication assessment, laboratory services and pharmacological services, if applicable.

3. Assessment and evaluation reports shall be used in service planning and copies of such reports shall be filed in the client's record.
4. Services shall be obtained for clients as specified in the client's individual treatment plan.
5. Level III behavioral health facilities providing supervised residential care shall provide, or arrange for, transportation as necessary for clients to attend such services specified in the client's individual service plan.
6. Life skills training, social and recreational activities, and milieu activities shall be provided, directly or by referral, during the hours when clients are not involved in other structured activities. Recreational and social activities shall be planned with client participation and posted in a conspicuous location.
7. Opportunity shall be provided for all clients to participate in religious services and other religious activities within the framework of their individual and family interests.
8. Orientation shall be provided to every client within 24 hours of admission to an agency and shall include the following:
   a. An explanation of the agency's services, activities, client performance expectations, agency policies and procedures, and agency rules;
   b. An orientation of the agency's premises and, if not contraindicated, the neighborhood and public transportation systems;
   c. A schedule of the client's activities;
   d. An explanation of the client rights and grievance procedures;
   e. A copy of the agency rules and client rights; and
   f. An introduction to agency personnel and other clients.
9. Agencies that provide supervised residential care shall ensure that transportation is available for clients to obtain the required services or treatment specified in the client's individual service plan.

B. Minimum staffing requirements for Level III facilities.
1. The agency shall have, at a minimum, the capability and staff to provide protective oversight and shall be staffed to the acuity of its clients.
2. The agency shall have an agreement or contract with a behavioral health emergency service provider to provide on-call consultation and intervention services as needed.
3. The agency shall contract for the services of a dietitian to review and approve all special diet menus and, annually, regular daily menus.

C. If an agency providing this level of service to a client population under 18 years of age is licensed by DES, such license shall be deemed adequate for behavioral health funding purposes.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

ARTICLE 9. EMERGENCY/CRISIS BEHAVIORAL HEALTH SERVICES

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-901. General Licensure Requirements for Emergency/Crisis Behavioral Health Services

A. In addition to requirements specified in R9-20-101 through R9-20-501, agencies providing emergency/crisis behavioral health services shall comply with the applicable requirements of this Article.

B. Emergency/crisis behavioral health services shall be provided by, or under the direction of, a behavioral health professional.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-902. Emergency/Crisis Behavioral Health Services

A. The agency shall develop and put into effect written procedures that govern the provision of the agency's emergency/crisis behavioral health services including the provision of services in a timely manner consistent with the presenting issue.

B. Service requirements for agencies which provide emergency behavioral health services:
1. Emergency services for clients who require a protected, supervised environment to reduce or eliminate an emergency situation and need to be kept overnight in an out-of-home setting, but who are not violent, suicidal or in need of medication stabilization, may be provided in a shelter agency. Such agencies shall, at a minimum, meet requirements of R9-20-801.
2. Emergency services for clients who are not violent, suicidal or in need of medication stabilization but who require protected, supervised out-of-home environment which offers short-term counseling and therapeutic activities to reduce or eliminate an emergency situation may be provided in a shelter agency. Such agencies shall, at a minimum, meet requirements of R9-20-701.
3. Emergency crisis services for clients who have been determined to be violent, in danger of harming themselves or others, or who are in need of medication stabilization and need to be kept overnight shall be provided only in a Level I behavioral health facility licensed to provide psychiatric acute care.
4. The agency shall have 24-hour staff coverage and on-call behavioral health professional consultation staff available to provide immediate telephone service;
5. Agency staff shall have the ability to contact, and provide clear concise information about the client and the emer-

gency situation to, the client's physician, case manager, counselor and/or family as necessary;

6. The agency shall have service agreements with the nearest emergency medical service transport agency, a local hospital, and law enforcement for assistance when determined to be necessary;
7. The agency shall determine circumstances under which definitive care should not be provided and procedures that should be followed in referring an individual to a more appropriate agency;
8. During regular operation hours, at least one member of the emergency service staff on duty shall have the education and training to perform first aid and cardiopulmonary resuscitation and to counsel clients who are experiencing acute distress due to behavioral health issues;

C. Staff members providing emergency service assessment, triage and counseling shall meet the qualification requirements of a behavioral health technician as stated in R9-20-306(C) under clinical supervision of a behavioral health professional pursuant to R9-20-306(B) or a clinical supervisor pursuant to R9-20- 307(B).

D. Emergency services shall be documented in the client record, to the extent the information is available, in accordance with the requirements in R9-20-407.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

R9-20-903. Mobile Crisis Services

A. Service requirements for mobile crisis services.

1. The agency shall have mobile crisis service coverage provided by teams staffed to operate 24 hours a day, 365 days a year.
2. On-call behavioral health professional consultation staff shall be immediately available for direct consulting 24 hours a day.
3. Agency staff providing emergency services shall evaluate the physical and psychological status of clients, the urgency of the situation, and the type of service available to best meet the client's needs.
4. Emergency service staff shall have the ability to perform first aid, cardiopulmonary resuscitation, and counsel clients who are experiencing acute distress due to behavioral health issues.
5. Agencies which provide non-ambulance transportation services to emergency service clients shall meet requirements specified in R9-20-413.
6. Ambulance services shall be licensed by the Department.

B. Minimum staff requirements for mobile crisis services:

1. Mobile crisis teams shall consist of at least two individuals; one member shall be a behavioral health technician pursuant to R9-20-306(C).
2. Emergency service staff shall have the training in first aid and cardiopulmonary resuscitation.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency punctuation error corrected pursuant to letter received in the Office of the Secretary of State October 19, 1993 (Supp. 93-4).

ARTICLE 10. OUTPATIENT SERVICES

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1001. Outpatient Clinic

A. In addition to requirements specified in R9-20-101 through R9-20-410, R9-20-413, and R9-20-501, agencies providing outpatient clinic services shall comply with the requirements of this rule.

B. Required services shall include the following:

1. Screening, assessment and evaluation services shall be provided by the agency or through a contract, including psychiatric evaluation, psychological testing, physical examination, medication assessment, laboratory services, pharmacological services, and observational assessment as indicated in the service plan;
   a. Such services should not be repeated upon admission if they have been provided for the client within the prior 45 days or there has not been a break in service delivery for a period greater than three days immediately prior to admission unless clinical indications are documented clearly and in detail in the client record.
   b. Copies of all assessment and evaluation reports shall be used in service planning and filed in the client's record.
   c. After hours of operation, the agency shall have a method to refer clients who are in need of an assessment or emergency/crisis counseling to an agency which provides such services on a 24-hour basis.
2. Psychotherapy or counseling services for a range of behavioral health issues including individual counseling, group therapy and family counseling.

C. The agency may also provide the following services:

1. Medication administration, adjustment and monitoring;
2. Emergency or crisis counseling;
3. Partial care programs; and
4. Transportation services.

D. Minimum staff requirements for services.

1. Assessment services shall be provided by staff members licensed or certified to provide applicable services. Behavioral health technicians may provide initial screening and assessment functions.
2. Counseling services or partial care shall be provided by a staff member licensed or certified under A.R.S. Title 32, or a behavioral health technician.
3. Medication monitoring and medication adjustment shall be provided by a licensed physician or psychiatrist, or other allied health professionals licensed or certified under A.R.S. Title 32 to provide such services.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under

an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency punctuation error corrected pursuant to letter received in the Office of the Secretary of State October 19, 1993 (Supp. 93-4).

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R9-20-1002. Outpatient Rehabilitation Agency

A. In addition to requirements specified in R9-20-101 through R9-20-410, R9-20-413, R9-20-501, and R9-20-1001, agencies providing outpatient rehabilitation services shall comply with the requirements of this rule.

B. Outpatient rehabilitation agencies shall provide all required services as specified in requirements for outpatient clinics plus one or more of the following services:

1. Intensive in-home services, if it is determined that the client requires intervention: and there is a need for behavioral health treatment services which are more intensive than traditional outpatient services; due to the risk of family dissolution; to minimize the need for out-of-home care or other more intensive services; or to facilitate family reunification during the transition period following out-of-home treatment services.
   a. Intensive in-home counseling shall be provided by a team of no less than two qualified staff members.
   b. Intensive in-home individual and family counseling services shall be available to the client and the client's family members in the magnitude indicated as necessary based on the client assessment, evaluation and diagnosis, and which is specified in the individual treatment plan. Services shall be provided, at any given time, based upon the acuity of the family system and condition.
   c. The agency shall have a method to refer clients who are in need of emergency/crisis counseling to an agency which provides such services on a 24-hour basis if the client's assigned in-home counselor is not available.
2. Home-based counseling, provided in the client's residence other than a hospital, or a Level I or II behavioral health facility when the client cannot obtain services at an outpatient clinic or when it is determined to be more beneficial in attaining goals and objectives in the client's treatment plan.
   a. Home-based counseling shall be provided by one or more qualified staff members who, at a minimum, meet requirements of a behavioral health technician.
   b. Home-based counseling shall be provided as specified by the individualized treatment plan.
   c. The agency shall have a method to refer clients who are in need of emergency/crisis counseling to an agency which provides such services on a 24-hour basis if the client's assigned in-home counselor is not available.
3. In-home supportive services which allow the client the opportunity to function as part of a household.
   a. Such services shall assist the client in developing independence in daily living.
   b. Such services may include vocational, educational, community and recreational opportunities.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-1003. Outpatient Detoxification Services

A. In addition to requirements specified in R9-20-101 through R9-20-410, R9-20-413, R9-20-501, and R9-20-1001, agencies providing outpatient detoxification services shall comply with the requirements of this rule.

B. Required detoxification services.

1. An outpatient behavioral health facility which provides detoxification services shall state in its program description the types of detoxification services available through the agency.
2. The agency shall maintain a structured treatment setting of managing the physiological manifestations and distress for clients who are experiencing symptoms of withdrawal from chemical dependency.
3. The agency shall have written policies and procedures governing the detoxification process utilized by the agency, overdose management, and methodologies to be used in cases of medical emergency.
4. The client's medical status and needs shall be assessed upon arrival at the agency.
5. Chemical dependency and detoxification services shall begin only upon a direct order from a physician defining the medical regimen to be followed. These services shall be available at the agency and shall include the following:
   a. Triage services to determine the need for medical care and transport to a hospital;
   b. Physical examination and chemical dependency assessment prior to initiation of the detoxification process. The agency may provide pharmacological services and medication administration;
   c. Close observational assessment and regular monitoring of vital signs;
   d. Nursing services during all hours of operation by licensed nurses in accordance with the Nurse Practice Act;
   e. Counseling, including individual, group, and family counseling;
   f. Activities to involve the client in interpersonal interactions;
   g. Psychiatric or psychological evaluation which shall be available as needed; and
   h. Referral to other service components or another appropriate treatment agency upon completion of detoxification.
6. Telephone numbers for poison control shall be readily available in the staff or nurse's station.

7. Clients who require treatment for an acute medical condition beyond the scope of the agency shall be referred to an inpatient hospital.
8. The agency shall provide, or have access to, transportation to a hospital inpatient unit on an emergency basis. Telephone numbers of ambulance services and other resources to provide transportation shall be posted in a conspicuous location in the facility.

C. Minimum staffing requirements:
1. Every outpatient behavioral health facility providing detoxification services shall have a physician on-site or on-call at all times, and the availability of the physician shall be documented.
2. Behavioral health personnel providing services to clients withdrawing from chemical dependency shall be knowledgeable of chemical dependency and symptomatology of withdrawal from the range of substances for which the agency provides detoxification. Personnel shall also be knowledgeable of symptoms of complications and medical problems associated with chemical dependency, effects and side effects of medications used in detoxification.
3. The agency shall provide, or make available through contract, other staff to provide services necessary to meet the treatment plan requirements for all clients, including psychiatric and psychological services and specialized counseling services.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

ARTICLE 11. BEHAVIORAL HEALTH CASE MANAGEMENT AGENCY

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1101. Behavioral Health Case Management Agency

In addition to requirements specified in R9-20-101 through R9-20-410, R9-20-413, and R9-20-501, behavioral health case management agencies shall comply with the applicable requirements of this Article.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1102. Service Requirements for Case Management Agencies

A. Case management and case coordination services shall be provided by a licensed behavioral health agency that specializes in case management and case coordination services.
1. Case management and case coordination services must be available 24 hours a day, 365 days a year.
2. Assessment, evaluation and diagnosis services may be provided by the same agency if the agency is in substantial compliance with requirements of R9-20-1201.

B. The agency shall develop and put into effect policies and procedures to govern all operational functions which meet requirements of this rule.

C. Case managers and case coordinators shall be in compliance with the requirements in R9-20-306(F) and shall demonstrate competency in the following areas prior to providing case management and case coordination services:
1. Managed care systems,
2. Provider networks,
3. Allocation of resources,
4. Philosophy of behavioral health programs,
5. Case management and case coordinator roles and responsibilities,
6. Case management and case coordination procedures and resources, and
7. Characteristics of behavioral health issues and levels of severity.

D. Case management or case coordination may be done by a behavioral health professional or behavioral health technician employed by a case management or case coordination agency.

E. Every case manager and case coordinator shall be supervised pursuant to R9-20-307(B).

F. Qualifications and demonstrated competency shall be documented in the employee's personnel record.

G. Every case manager and case coordinator shall obtain training to meet any unique needs of the clients assigned to the case manager's or case coordinator's caseload.

H. Case management and case coordination services shall be staffed to acuity and shall be limited if the caseload consists of clients who are determined to be seriously mentally ill or require 24-hour supervision or are in need of intensive intervention or intensive case management services.

I. Case management services may be provided through face-to-face contact, telephone contact, collateral contacts, and support.

J. If direct treatment services are provided, the agency shall meet the additional requirements of Article 10 of this Chapter.

K. Psychiatrists and other behavioral health professionals providing SMI clinical case management services shall meet the requirements of R9-20-306(B).

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency error in subsection (K) corrected pursuant to letter received in the Office of the Secretary of State October 8, 1993 (Supp. 93-4).

ARTICLE 12. ASSESSMENT, EVALUATION, AND DIAGNOSIS SERVICE AGENCIES

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1201. Assessment, Evaluation, and Diagnosis Service Agency

A. Agencies which provide assessment, evaluation, and diagnosis services shall comply with R9-20-101 through R9-20-403, R9-20-405, R9-20-406, R9-20-409, R9-20-410, and R9-20-501 in addition to this Article.

B. Such services shall be provided under the direction of the clinical director who shall be a psychiatrist, licensed physician if the physician has postgraduate training and experience in diagnosis and treatment of behavioral health issues and disorders, or behavioral health professional.

C. Upon completion of assessment, evaluation and diagnosis, clients shall be referred to a licensed behavioral health service agency or hospital for treatment services determined to be needed by the client and to a case management agency.

D. Services may be provided at the agency offices or at the client's location.

E. An agency providing assessment, evaluation and diagnosis services shall be licensed under Article 10 of this Chapter if providing treatment services.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

ARTICLE 13. SHELTERS; HALFWAY HOUSES

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1301. Shelters; Shelter Services

In addition to requirements specified in R9-20-101 through R9-20-201, R9-20-405(A), and R9-20-505(F), shelters shall comply with the applicable requirements of this Article, if not licensed pursuant to Article 7 or 8 of this Chapter.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-1302. Manager Qualifications and Responsibilities

A. The governing authority shall appoint a manager who shall be responsible for the operation of the shelter and who shall meet one of the personnel qualification requirements in R9-20-306(C).

B. The manager shall be responsible for establishing and implementing policies and procedures governing:

1. Client rights and responsibilities;
2. A fire and safety plan developed in accordance with guidelines provided by the appropriate local authority;
3. Admission and discharge of clients;
4. Client services, treatment, or care;
5. Client confidentiality;
6. Unauthorized entry to or exit from the shelter by clients, staff, or other individuals;
7. Medications administration;
8. Client nutrition;
9. Client record confidentiality, storage, transportation, and dissemination of identifying information; and
10. Periodic review of the agency's policy and procedure manual as indicated by the dated signature of the manager.

C. The manager shall ensure that the shelter operates on a 24-hour basis, including intake and placement and, if a vacancy does not exist, the manager shall ensure that assistance is provided to an individual seeking shelter or alternative care.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency errors in subsections (B)(8) and (9) corrected pursuant to letter received in the Office of the Secretary of State October 19, 1993 (Supp. 93-4).

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R9-20-1303. Staffing Requirements

A. Shelters shall have no less than one staff member on the premises when clients are present.

B. Shelter staff shall be available to provide crisis intervention, counseling, skills training, support, and recreation as needed.

C. During regular operation hours, no less than one member of the emergency service staff on duty shall have the education and training to perform first aid and cardiopulmonary resuscitation and to counsel clients who are experiencing acute distress due to behavioral health issues.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-1304. Residency Requirements
Shelter residency shall be in accordance with the client's individualized service plan and the agency's policies.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-1305. Environmental Standards
A. Every shelter shall be licensed for a specific number of residents.
B. The capacity of a shelter shall be based on available living space and shall take into consideration all clients and staff living on the premises.
C. Provision shall be made for a dining area. The dining area shall not be used as a sleeping area.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency error in subsection (C) corrected pursuant to letter received in the Office of the Secretary of State October 19, 1993 (Supp. 93-4).

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R9-20-1306. Required Recordkeeping
The manager shall ensure that the following records are maintained:
1. All current required operating licenses, permits and certificates.
2. Resident logs, including identifying information; the name of an emergency contact; the name and number of the resident's case manager; a list of the resident's medication; treatment plans or records, if applicable; and a forwarding address for the resident, if available. Shelters which provide behavioral health services to domestic violence victims shall not be required to maintain resident logs if the agency maintains compliance with the documentation requirements of subsection (C).
3. Client file documentation which shall contain:
   a. Information generated as a result of the client's assessment and evaluation,
   b. Treatment plans and updates prepared to ensure goals and objectives specified in the treatment plan are addressed,
   c. Treatment or staffing summaries,
   d. Notation of contacts or referrals, and
   e. Discharge summaries from the provider agency.
4. Reports of all inspections and reviews, including fire and sanitation reports, with documentation of all corrective actions taken.
5. Reports of fire drills.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-1307. Fire and Safety
A. Smoke detectors shall be maintained in working order near every sleeping and cooking area. Battery-powered smoke detectors may be utilized.
B. Fire drills shall be conducted on a quarterly basis. All residents and staff shall participate in fire drills.
C. A first-aid kit shall be kept in the shelter and accessible to all personnel.
D. A list of emergency numbers and poison centers numbers shall be maintained near a telephone for easy access by staff and clients.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1308. Halfway Houses; Halfway House Services

In addition to requirements specified in R9-20-101 through R9-20-201, R9-20-405(A) and R9-20-505(F), halfway houses shall comply with the applicable requirements of this Article, if not licensed pursuant to Article 7 or 8 of this Chapter.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1309. Manager Qualifications and Responsibilities

A. The governing authority shall appoint a manager who shall be responsible for the operation of the halfway house and who shall meet one of the personnel qualification requirements in R9-20-306(C).

B. The manager shall be responsible for establishing and implementing policies and procedures governing:

1. Client rights and responsibilities;
2. A fire and safety plan developed in accordance with guidelines provided by the appropriate local authority;
3. Client services, treatment, or care;
4. Unauthorized entry to or exit from the shelter by clients, staff, or other individuals.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency error in subsection (A) corrected pursuant to letter received in the Office of the Secretary of State October 19, 1993 (Supp. 93-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1310. Staffing Requirements

A. Halfway house staff shall be available to provide skills training, support, and recreation as needed.

B. During regular operation hours, no less than one member of the emergency service staff on duty shall have the education and training to perform first aid, cardiopulmonary resuscitation, and counsel clients who are experiencing acute distress due to behavioral health issues.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1311. Residency Requirements

Halfway house residency must be in accordance with the client's individualized service plan and the agency's policies.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1312. Environmental Standards

A. Every halfway house shall be licensed for a specific number of residents.

B. The capacity of a halfway house shall be based on available living space and shall take into consideration all clients and staff living on the premises.

C. Provision shall be made for a dining area. The dining area shall not be used as sleeping area.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1313. Required Recordkeeping

The manager shall ensure that the following records are maintained:

1. All current required operating licenses, permits, and certificates.
2. Resident logs, including identifying information; the name of an emergency contact; the name and number of the resident's case manager; and, if applicable, a list of the resident's medication, treatment plans, or records; and the residents' forwarding address, if available.

3. Reports of all inspections and reviews, including fire and sanitation reports, with documentation of all corrective actions taken.
4. Reports of fire drills.
5. Copies of all current contracts for health care services provided within the facility.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1314. Fire and Safety

A. Smoke detectors shall be maintained in working order near every sleeping and cooking area. Battery-powered smoke detectors may be utilized.

B. Fire drills shall be conducted on a quarterly basis. All residents and staff must participate in fire drills.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

ARTICLE 14. PRE-PETITION SCREENING; COURT-ORDERED SERVICES

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1401. Pre-petition Screening

A. Unless there are specific provisions otherwise in this Article, each agency providing pre-petition mental health screening shall comply with A.R.S. Title 36, Chapter 5 and the provisions of this Chapter as determined by the outpatient or residential treatment setting.

B. The person against whom a petition has been filed shall be notified of the individual's right to select one of the physicians. A psychiatric resident in a training program approved by the American Medical Association or by the American Osteopathic Association may examine the person in place of one of the psychiatrists if supervised in the examination and preparation of the affidavit and testimony in court by a qualified psychiatrist appointed to assist in the resident's training, and if the supervising psychiatrist is available for discussion with the attorneys for all parties and for court appearance and testimony if requested by the court or any of the attorneys.

C. The pre-petition screening shall be provided within 48 hours of receipt of the application for evaluation, excluding weekends and holidays, pursuant to A.R.S. Title 36, Chapter 5.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency error in subsection (B) corrected pursuant to letter received in the Office of the Secretary of State October 19, 1993 (Supp. 93-4).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1402. Court-ordered Mental Health Evaluation and Treatment

A. Unless there are specific provisions otherwise in this Article, each agency providing court-ordered evaluation or treatment shall comply A.R.S. Title 36, Chapter 5 and the provisions of this Chapter as determined by the outpatient or residential treatment setting.

B. The professional multidisciplinary analysis or evaluation is based on data describing the person's identity, biography, and conditions and carried out by a group of persons consisting of not less than the following:
1. Two licensed physicians, who shall be qualified psychiatrists, if possible, or experienced in psychiatric matters, and who shall examine the individual in a direct face-to-face interview and report their findings independently.
2. Two other individuals, one of whom, if available, shall be a psychologist and in any event a social worker familiar with mental health and human services which may be available placement alternatives for treatment. An evaluation may be conducted on an inpatient basis, an outpatient basis, or a combination of both, and every attempt shall be made to conduct the evaluation in any language preferred by the person.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1403. Court-ordered Alcoholism Treatment Services

Unless there are specific provisions otherwise in this Article, each agency providing court-ordered alcoholism treatment services shall comply with A.R.S. Title 36, Chapter 18 and the provisions of this Chapter.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

ARTICLE 15. REPEALED

Editor's Note: The following Section was adopted and repealed under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1501. Repealed

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Repealed under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

ARTICLE 16. PARTIAL CARE SERVICES

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1601. Partial Care Licensure Requirements

A. Unless there are specific provisions otherwise in this Article, each agency providing partial care services shall be licensed in accordance with this Chapter as an outpatient or residential treatment or hospital setting.

B. After hours of operation, the agency shall have a method to refer clients who are in need of an assessment or emergency/crisis counseling to an agency which provides such services on a 24-hour basis.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1602. Basic Partial Care Services

A. Basic partial care service shall include treatment services following residential or inpatient treatment or to prevent placement in a more restrictive setting.

B. The agency shall provide and have written policies and procedures for a structured, coordinated program of goal-oriented services designed to provide therapeutic activities.

1. Assessment and evaluation services:
   a. Such services shall not be repeated upon admission if they have been provided for the client within the prior 45 days or there has not been a break in service delivery for a period greater than three days immediately prior to admission unless clinical indications are documented in detail in the client record.
   b. All available assessment and evaluation reports shall be used in service planning and filed in the client's record.
2. Supportive counseling such as life skills training, psychosocial rehabilitation, independent living skills training, drug-free or alcohol-free alternatives with creative activities in a substance-free setting as required by the client's individualized treatment plan.
3. Transportation services as indicated by the individualized client treatment plan.

C. Behavioral health service agencies shall meet the following staffing requirements:

1. Assessment services shall be provided by a psychiatrist, psychologist, or behavioral health professional. Initial screening and assessment functions may be conducted by a behavioral health technician if supervised by a clinical supervisor pursuant to R9-20-307(B).
2. Counseling services shall be provided by a psychiatrist, psychologist, behavioral health professional, or behavioral health technician who is supervised pursuant to R9-20-307(B).
3. The caseload for every staff member providing partial care services shall be based on client acuity.

D. Each licensed agency shall have basic partial care services available to clients for a minimum of three hours per day, three days each week.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-1603. Intensive Partial Care Services

A. An agency providing intensive partial care services shall have policies and procedures covering the provision of a structured, coordinated program of intensive care which is scheduled on a regular basis, providing active treatment intended to lead to

full or partial resolution of the client's acute or episodic behavioral health issues.

B. Intensive partial care services shall include:
1. Individual, group and/or family therapy;
2. Treatment-related activities intended to reduce the need for more intensive services; and
3. Medication monitoring and medication adjustment.

C. Agencies providing intensive partial care shall staff as follows:
1. A psychiatrist shall examine each client on-site a minimum of once every 14 days.
2. Intensive partial care services shall be provided by a behavioral health professional or a behavioral health technician supervised by a clinical supervisor pursuant to R9-20-307(B) and under the direction of a psychiatrist or psychologist.

D. Each licensed agency shall have intensive partial care services available for clients for a minimum of three hours per day, three days each week.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 23, 1992; received in the Office of the Secretary of State November 9, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

ARTICLE 17. DUI SERVICE AGENCIES

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1701. Definitions

In this Article, unless the context otherwise requires:
1. "AC" means alcohol concentration.
2. "Approval" means the certificate or license issued, by the Department, which authorizes an entity to operate as a DUI service agency.
3. "Client" means an individual who is receiving DUI services because of a DUI conviction and has been ordered by the court to participate in a Department-approved screening, education, and/or treatment program pursuant to A.R.S. § 28-692.01.
4. "Department" means the Department of Health Services.
5. "DUI" means driving under the influence of intoxicating liquor, any drug, or vapor-releasing substance containing a toxic substance or any combination of liquor, drugs, or vapor-releasing substances.
6. "DUI education agency" means an entity approved by the Department to provide DUI education services.
7. "DUI education service" means the provision of alcohol and/or drug abuse information to offenders.
8. "DUI screening agency" means an entity approved by the Department to provide DUI screening services.
9. "DUI screening service" means the preliminary interview and assessment of an offender to determine whether education or treatment is required and referral made to a DUI education or treatment agency.
10. "DUI service" means screening, education, and/or treatment services provided to offenders.
11. "DUI service agency" means an entity approved by the Department to provide screening, education, and/or treatment services to offenders.
12. "DUI treatment agency" means an entity approved by the Department to provide DUI treatment services.
13. "DUI treatment service" means clinically recognized service interventions provided to clients who habitually abuse alcohol or drugs.
14. "Facility" means the site or location at which DUI screening, education, or treatment services are provided.
15. "Governing authority" means one or more individuals who are responsible for the organization, administration, and management of a DUI service agency.
16. "Habitual abuse" means chronic or compulsive use of any drug or alcohol which, when introduced into the body in any way, is capable of causing altered human behavior or altered mental functioning, and which, if used over an extended period of time, may cause psychological or physiological dependence or impaired mental, social, or economic functioning.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1702. DUI Service Agency Requirements

A. A DUI service agency that is seeking to provide DUI treatment services shall submit an application provided by the Department to obtain licensure to operate as a DUI service agency pursuant to A.R.S. Title 36, Chapters 4, 5 and 18; and Article 1 of this Chapter. The application shall also include a schedule of fees for services to be provided.

B. A DUI service agency that is seeking to provide DUI screening or education services shall submit an application to the Department for approval to operate as a DUI service agency pursuant to A.R.S. Title 36, Chapter 18. The application shall also include a schedule of fees for services to be provided.

C. The DUI service agency governing authority shall be responsible for adopting organizational bylaws and policies and procedures that govern the administration and management of the agency, including:
1. Adopting a written operational statement of program services and activities that describe:
   a. Type of services offered,
   b. Client provisions,
   c. Fee policies,
   d. Target populations,
   e. Service sites, and
   f. Hours of operation;
2. Ensuring that the DUI service agency is operating in accordance with Department-approved standards;
3. Appointing an administrator who shall have the authority and responsibility for the agency's operations and provision of DUI services;
4. Notifying the Department of any change in administrative staff, program, or location not less than 30 days prior to any change; and

5. Notifying the Department and clients of any change in the schedule of fees not less than 30 days prior to any change.

D. The provisions in this Article shall not apply to:
1. Drug- or alcohol-abuse screening, education or treatment services provided to individuals who are not DUI clients; or
2. Behavioral health service agencies on military bases, other governmental agencies, or those owned or operated by Indian tribes on federally designated reservations.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1703. Administration

A. The administrator shall be responsible for the management of the agency's administrative program operations and shall:
1. Establish and maintain the agency's policies and procedures;
2. Establish written personnel policies and procedures describing the duties, responsibilities, and qualifications of personnel;
3. Establish standards that govern the ethical conduct of personnel and confidentiality of information regarding clients and client records;
4. Appoint professional staff and supporting personnel to provide DUI services;
5. Ensure staff orientation, training, and development and supervision;
6. Ensure that agency, program, and client records are maintained and available to the Department;
7. Ensure that personnel records are maintained and include signed and dated job descriptions, personnel qualifications and documentation of orientation and annual continuing education and training;
8. Ensure that clients receive a schedule of fees for DUI services provided which shall include the cost of program materials pursuant to R9-20-112;
9. Ensure that client rights and client confidentiality are maintained pursuant to 42 CFR 2, October 1, 1992, which is incorporated herein by reference and on file with the Office of the Secretary of State and R9-20-201;
10. Designate, in writing, an acting administrator who shall be 21 years or older and who shall have access to all areas within the agency that are related to client care when the administrator is absent;
11. Ensure that performance evaluations are conducted annually and documented in personnel files; and
12. Ensure that one or more staff members, who have current certification in first aid and cardiopulmonary resuscitation from Department-approved programs, shall be present at all times whenever clients are present in the agency or on supervised outings.

B. The administrator shall ensure that the agency and personnel are in compliance with A.R.S. § § 13-3716 and 36-425(03). There shall be supporting documentation maintained by the agency which shall be available for inspection by the Department.

C. Volunteers who provide services to children under the direct visual supervision of staff of an approved DUI service agency are exempt from the fingerprinting requirements pursuant to A.R.S. § 36-425.03(J).

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-1704. Personnel

A. Each employee who is hired to conduct screening and education services shall:
1. Hold a bachelor's degree in a field related to behavioral health from an accredited college or university; or
2. Hold an associate's degree in a field related to behavioral health from an accredited college or university and shall have a minimum of two years' documented experience in the clinical treatment of alcohol and/or drug abuse; or
3. Hold a high school diploma or equivalent and have a combination of two years in behavioral health education and documented experience.

B. Each employee who is hired to conduct treatment services shall:
1. Hold a bachelor's degree in a field related to behavioral health from an accredited college or university; or
2. Hold an associate's degree in a field related to behavioral health from an accredited college or university and shall have a minimum of two years' documented experience in the clinical treatment of alcohol and/or drug abuse.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-1705. Staff Supervision

A. The administrator shall ensure that direct clinical staff supervision is provided by one of the following:
1. A psychiatrist licensed pursuant to A.R.S. Title 32, Chapter 13 or 17;
2. A psychologist licensed pursuant to A.R.S. Title 32, Chapter 19.1;
3. A counselor certified by the Arizona Board for Certification of Addiction Counselors;

4. A professional certified by the Board of Behavioral Health Examiners pursuant to A.R.S. Title 32, Chapter 33;
5. An individual who holds an associate degree in a field of study related to human services from an accredited college and who has a minimum of five years of practical experience relevant to the area of supervision;
6. An individual who holds a bachelor's degree in a field of study related to human services from an accredited college or university and who has a minimum of three years of practical experience relevant to the area of supervision;
7. An individual who holds a master's degree in a field of study related to human services from an accredited university and who has a minimum of two years of practical experience relevant to the area of supervision;
8. An individual who holds a doctorate in a field related to human services from an accredited university and who has a minimum of one year of clinical experience relevant to the area of supervision; and
9. A registered nurse who has a minimum of one year of experience in a behavioral health setting.

B. The administrator shall ensure that clinical staff supervision is provided as follows:
1. Each behavioral health technician employed by a residential or inpatient facility shall receive a minimum of one hour per week of clinical supervision from a behavioral health professional or clinical supervisor.
2. Each behavioral health technician or paraprofessional employed by an outpatient facility shall receive a minimum of four hours per month of clinical supervision.

C. The administrator shall ensure that clinical staff supervision is documented to include the following:
1. Employee participation in counseling activities,
2. Employee skills in client recordkeeping,
3. Employee capabilities in providing therapeutic services to clients, and
4. Employee training to improve job performance.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1706. Staff Development and Training

A. The administrator of a DUI service agency shall ensure that staff are provided initial orientation and ongoing training. The training shall consist of a review of program policies and procedures and client recordkeeping.

B. Each employee who provides DUI screening and education services shall complete eight hours of initial orientation and, annually thereafter, 24 hours of continuing education or in-service training in alcohol and/or drug treatment and prevention.

C. Each employee who provides DUI treatment services shall meet the staff development and training requirements in R9-20-308.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-1707. DUI Screening Services

A. An administrator of a DUI service agency that is providing court-ordered DUI screening services shall:
1. Develop a court referral system for the completion of a screening process within 30 working days of the date of the court order for screening. The system shall include the development of written procedures for handling referrals or court orders and shall include the following information:
   a. Date of expected completion of the screening process by the client;
   b. Consequences, to the client, of not complying with court-ordered screening within the designated time frame;
   c. Cost of the screening and the method by which the fee shall be paid;
   d. Reporting to the court:
      i. The client's AC;
      ii. Prior DUI offenses;
      iii. Screening results;
      iv. Recommended education and/or treatment;
      v. Agency selection; and
      vi. The client's compliance with, and progress in, an education and/or treatment program.
2. Develop, in consultation with the referring court, policies and procedures which shall include time frames and required forms to be used for submitting written notification to the referring court for the following:
   a. Failure, by the client, to obtain court-ordered screening within five working days of the missed screening appointment or court-specified deadline.
   b. Failure, by the client, to pay the financial costs of the screening program as scheduled.
   c. Failure, by the client, to complete the screening program or the client's noncompliance as reported by the DUI education or treatment agency. The court shall be notified within five working days of notice.
   d. Completion, by the client, as certified by the DUI service agency, of court-ordered DUI education or treatment.

B. The screening services program shall begin with a personal interview of the client which shall not be less than 30 minutes, nor more than three hours, and shall utilize one or more of the following assessment instruments:
1. Driver Risk Inventory;
2. Michigan Alcoholism Screening Test;
3. Minnesota Multiphasic Personality Inventory;
4. Mortimer-Filkins; and
5. Other instruments, inclusive of any juvenile assessment instrument, shall be submitted to the Department, prior to utilization.

C. Each client shall be classified according to the following criteria:
1. A client shall be classified a Level I alcohol or drug abuser if the client, prior to court-ordered DUI screening:
   a. Exhibited one or more of the following indicators:
      i. Two or more previous alcohol- or drug-related arrests or convictions;
      ii. Inability to control or habitual abuse of alcohol or drugs;
      iii. Self-admission of problem with alcohol or drug use;
      iv. Prior diagnosis by a competent authority of alcohol or drug abuse;
      v. Organic brain disease associated with alcohol or drug abuse;
      vi. Major alcohol or drug withdrawal symptoms, including:
         (1) Alcoholic hallucinosis (visual, auditory, or tactile);
         (2) Convulsive seizures; or
         (3) Delirium tremens;
      vii. Medical diagnosis of physical complications:
         (1) Alcoholic liver disease (fatty liver, hepatitis or cirrhosis);
         (2) Alcoholic pancreatitis; or
         (3) Alcoholic cardiomyopathy; or
   b. Exhibited three or more of the following indicators:
      i. Screening assessment indicates problems with or abuse of alcohol or drugs;
      ii. AC of .15 or higher;
      iii. One prior alcohol- or drug-related arrest or conviction;
      iv. Attendance or productivity decrease at work or school;
      v. Family, peer, and/or social problems associated with alcohol or drug use;
      vi. Previous participation in, or contact with, substance abuse education, treatment, or medical facilities for problems associated with alcohol or drug use;
      vii. Blackouts associated with alcohol or drug use;
      viii. Passing out associated with alcohol or drug use;
      ix. Withdrawal symptoms including:
         (1) Shakes or malaise relieved by resumed drinking,
         (2) Irritability,
         (3) Nausea, or
         (4) Anxiety;
      x. Psychological dependence on alcohol or drugs;
      xi. Increase in consumption or tolerance or change in the pattern of drinking; or
      xii. Personality changes associated with alcohol and/or drug use.
2. A client shall be classified a Level II potential alcohol or drug abuser who has, prior to court-ordered DUI screening, exhibited two or more of the indicators in subparagraph (b).
3. A client shall be classified a Level III non-problem alcohol or drug user who has, prior to court-ordered DUI screening, exhibited no more than one of the indicators listed in subparagraph (b).

D. Each client shall be referred for education or treatment as follows:
1. A Level I client shall be referred to a licensed DUI treatment program for a minimum of 20 hours. The DUI treatment agency may order a more intensive program of treatment if the agency determines the client requires additional care. The DUI screening agency may also require that a client participate in self-help programs.
2. The DUI Level II clients shall be referred to a Department-approved DUI education program for a minimum of 16 hours. A client may also be required to participate in self-help programs by the screening agency.
3. Level III clients shall be referred to a Department-approved DUI education program for a minimum of eight hours. A client may also be required to participate in self-help programs by the screening agency.

E. The DUI screening agency shall determine if the client requires additional care or participation and shall document this information in the client's screening record.

F. Upon completion of the screening program, the DUI screening agency shall:
1. Document the results of the screening on Department-approved forms which shall include:
   a. The AC level at the time of arrest;
   b. A history of alcohol or drug use;
   c. Previous treatment;
   d. Impairments in medical, social, or occupational functioning due to alcohol or drug use; and
   e. Recommendation regarding education and treatment.
2. Provide the client with names of three or more DUI service agencies which provide the recommended education or treatment and advise the client to select an agency and schedule an appointment for education and treatment within five days from the completed date of screening.
3. Advise the client, in writing, of the DUI screening agency's procedures, time frames, and consequences of the client's noncompliance and require the client to sign and date the document.
4. Require the client to sign a release of information form for referral to the selected DUI education or treatment agency.
5. Within five working days of the client's completion of the screening program, submit a written referral to the DUI education or treatment agency together with a summary of screening results and recommendations for education or treatment.

Historical Note

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R9-20-1708. DUI Client Screening Records

A. An administrator shall ensure that a record is maintained for each client who receives screening services and shall include the following information:
1. Client name, address, telephone number, date of birth, citation or complaint number, and person to notify in case of emergency;
2. A copy of the documents referring client for court-ordered screening;

3. Documentation of any alternative referrals and program completion requirements pursuant to R9-20-1707(E) and (F);
4. A copy of the written notification sent to the referring court regarding the screening results;
5. Documentation, if applicable, that the court was notified within five working days that the client was in noncompliance with an education or treatment program as determined by the designated DUI education or treatment agency; and
6. Documentation that the client and designated representative, if any, was provided information on the cost of the screening program and any subsequent fees to be incurred for education or treatment.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-1709. DUI Education Services

A. An administrator of a DUI service agency that is providing DUI education services shall ensure the following:
1. Policies and procedures are developed for submitting written notification to the referring DUI screening agency regarding the following:
   a. The client's completion of the required education program. Such notification shall be sent within five working days of completion.
   b. The client's failure to enroll in a required education program. Such notification shall be sent within five working days of the screening program completion.
   c. The client's failure to comply with the provisions of the required education program, including attendance and nonpayment. Such notification shall be sent within five working days of the occurrence.
2. DUI education services shall be provided in a classroom setting with not more than 30 participants for a Level II education class or 40 participants for a Level III education class.
3. Level II group process orientation sessions shall not exceed 15 participants and one DUI staff member.
4. Department approval shall be obtained prior to using any non-English curriculum and printed materials or any pre-program and post-program tests that measure outcome.
5. Each client enrolled in a Level II education program shall be advised on class progress, recommendations for therapy or self-help groups, and the content of the report which shall be forwarded to the referring screening agency and court concerning the client's participation in the education program.
6. A regular schedule of classes shall be maintained and available to the Department.

B. Level II education classes shall consist of 16 hours of participation which shall be completed within eight consecutive weeks. The Level II curriculum shall include the following subjects:
1. Alcohol as a drug and its physiological effects;
2. Effects of legal and illegal drugs on driving;
3. Psychological and sociological consequences of use or abuse of alcohol or drugs and the stages of dependency and defense mechanisms;
4. AC, its calculation and effects on driving performance;
5. Criminal penalties and statutory requirements for sentencing of DUI clients;
6. Community resources and interventions;
7. Review of treatment approaches and various programs;
8. Self-assessment of alcohol and drug use in an interactive or social setting;
9. Alternatives to drinking or using drugs and driving;
10. Orientation to therapy sessions with emphasis on group process and orientation to self-help groups such as Alcoholics Anonymous and Narcotic Anonymous; and
11. A pre-program and post-program test capable of providing measurable outcome.

C. Level III education classes shall consist of a minimum of eight hours of class time which shall be completed within four consecutive weeks. The Level III curriculum shall include subsection (B)(1) through (9) only of the Level II curriculum.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency errors in subsection (B)(9) and (10) corrected pursuant to letter received in the Office of the Secretary of State October 19, 1993 (Supp. 93-4).

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R9-20-1710. DUI Client Education Records

The administrator shall ensure that a record is maintained for each client enrolled in a Level II or Level III education program and shall include the following information:
1. Screening agency referral documents;
2. Pre-program and post-program test results;
3. Program attendance and completion data;
4. Documentation that the client and designated representative, if any, was provided information on the cost of the education program and any subsequent fees to be incurred for more education or treatment;
5. Documentation of all telephone contacts and information exchanged verbally with the referring DUI screening agency, the court and, if applicable, the Department of Motor Vehicles (DMV), and any referral to the DUI treatment agency;
6. Documentation that the client was provided information pursuant to R9-20-1709(B)(1) through (B)(9); and
7. A copy of the certificate of satisfactory completion of the education program.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-1711. DUI Treatment Services

A. Agencies providing DUI outpatient treatment services shall comply with the requirements specified in R9-20-101 through R9-20-406, R9-20-501, and R9-20-1001 in addition to the applicable requirements of this Article.

B. An administrator of a DUI service agency that is providing DUI treatment services shall:
1. Develop policies and procedures for notifying the referring DUI screening agency of the following:
   a. The client's absence from the treatment program within five working days of the missed session.
   b. The client's completion of the required hours of treatment within five working days of the date of completion.
   c. The client's failure to pay the financial costs of the treatment program.
2. Develop referrals to self-help groups such as Alcoholics Anonymous and Narcotics Anonymous shall not be substituted for participation in court-ordered treatment.
3. Appoint a clinical director who shall supervise the provision of DUI services.

C. DUI treatment services shall consist of:
1. Twenty hours of DUI treatment services for a client that are provided in a minimum of ten individual or group sessions within four months of the first treatment visit.
2. An individualized treatment plan for each client, including the number of required outpatient sessions, based upon:
   a. A face-to-face interview with each client to determine individual goals;
   b. Information and screening results provided by the referring DUI screening agency; and
   c. Intake information.
3. Group therapy sessions that last 90 minutes or more and do not exceed 15 clients and one counselor. Client family members and significant others may participate in group sessions, but the total number of participants shall not exceed 20.
4. An exit interview with each client to advise the client of:
   a. Treatment progress,
   b. Recommendations for therapy or self-help groups, and
   c. Content of the report to the referring screening agency and court concerning the client's participation in the treatment program.

D. A DUI treatment agency may require the Level II education program as a prerequisite to admission to Level I, but the 16 hours of Level II education shall not be credited toward the 20 hours of required treatment for Level I.

E. A DUI treatment agency may refer a client back to the screening agency for any of the following:
1. The treatment agency has determined that the client needs specialized services in behavioral health counseling, services for the handicapped, or services in a non-English language. Hours of services provided by these agencies may be counted in the total hours required for Level I clients as ordered by the court.
2. The DUI treatment agency is unable to provide the recommended treatment. It shall provide the screening agency with the reasons and recommended alternatives.
3. The DUI treatment agency has determined that the client needs a more intensive treatment program in a residential, inpatient, or outpatient facility.

Historical Note

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R9-20-1712. DUI Client Treatment Records

The administrator of a DUI service agency shall ensure that a record is maintained for each client receiving treatment services pursuant to R9-20-405 and R9-20-406 of this Chapter and shall include the following additional information:
1. Screening referral documents;
2. Attendance and participation in treatment program data;
3. Results of the referring screening agency's assessment and recommendations or any other evaluation, diagnostic information, or test results from other service providers which were used in developing the individualized treatment plan;
4. Individual progress notes describing the client's participation and progress toward meeting goals defined in the treatment plan;
5. Documentation of verbal contacts and written reports or correspondence with the courts, the referring screening agency, and the DMV, if applicable;
6. Documentation of the client's exit interview pursuant to R9-20-1711(C)(4); and
7. A copy of the certificate of satisfactory completion of the treatment program.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency error in paragraph (6) corrected pursuant to letter received in the Office of the Secretary of State October 19, 1993 (Supp. 93-4).

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R9-20-1713. Physical Plant Requirements

A. The physical plant of each DUI service agency shall conform to local building, zoning, and fire prevention authorities, where applicable.

B. The building shall be clean, sanitary, and in good repair and shall contain:
1. A toilet and lavatory which provides privacy and is kept clean and maintained for use by the agency staff, clients, and visitors.

2. A basic emergency first-aid equipment kit and supplies where client services are provided.
3. Heating and cooling systems which meet state and local building codes. Unvented or open flame space heaters shall not be used.
4. Rooms that allow auditory and visual privacy for client interviews, individual counseling, and other therapeutic activities and waiting rooms for clients or visitors.

C. The administrator shall ensure that an emergency evacuation plan is posted where services are provided in case of fire or other disasters.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

ARTICLE 18. METHADONE OR METHADONE-LIKE TREATMENT AGENCIES

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1801. Definitions

A. In this Article, unless the context otherwise requires:
1. "Assistant director" means the assistant director of Health and Child Care Review Services in the Department of Health Services.
2. "Comprehensive maintenance treatment" means methadone or methadone-like maintenance treatment which is provided in conjunction with a comprehensive range of appropriate counseling, medical, and rehabilitative services.
3. "Detoxification treatment" means the dispensing of a narcotic drug in decreasing doses to an individual to alleviate adverse physiological or psychological effects incident to withdrawal from the continuous or sustained use of a narcotic drug and as a method of bringing the individual to a drug-free state within such period.
4. "Licensed private practitioner" means an individual licensed pursuant to A.R.S. Title 32.
5. "Long-term detoxification treatment" means a continuous period of treatment of not less than 31 days but which does not exceed 180 days.
6. "Medical director" means a physician licensed pursuant to A.R.S. Title 32, Chapter 13 or 17, and who is responsible for the management of the agency's medical services.
7. "Medication unit" means a facility established as part of a methadone or methadone-like treatment program, but geographically dispersed, from which licensed private practitioners and community pharmacists are:
   a. Permitted to administer and dispense a narcotic drug;
   b. Authorized to collect samples for drug testing or analysis for narcotic drugs.
8. "Methadone or methadone-like treatment" means the dispensing of a narcotic drug in the treatment of an individual for dependence on heroin or other morphine-like drug.
9. "Methadone or methadone-like treatment program" means the service delivery component of an agency licensed by the Department which administers or dispenses a narcotic drug to a narcotic addict for maintenance or short- or long-term detoxification treatment, which provides a comprehensive range of medical, counseling, and rehabilitative services, and which is approved by the Food and Drug Administration and registered with the Drug Enforcement Administration.
10. "Narcotic dependent" means an individual who physiologically needs heroin or a morphine-like drug to prevent the onset of signs of withdrawal.
11. "Program sponsor" or administrator means the individual who is responsible for the operation of a methadone or methadone-like treatment program, including all employees, practitioners, agents, or other persons providing services at the program, including its medication units.
12. "Services" means the medical evaluations, counseling, rehabilitative, and other social programs, vocational and educational guidance, employment placement, which will assist the client to become a productive member of society.
13. "Short-term detoxification treatment" means a continuous period of treatment not to exceed 30 days.

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R9-20-1802. Methadone or Methadone-like Treatment Service Agency Requirements

A. In addition to the requirements of this Article agencies seeking to provide methadone or methadone-like outpatient treatment services shall comply with R9-20-101 through R9-20-410, R9-20-413, R9-20-501, R9-20-1001, and R9-20-1003.

B. The methadone treatment agency governing authority shall be responsible for adopting organizational bylaws and policies and procedures that govern the administration and management of the agency, including:
1. Adopting a written operational statement of program services and activities that describe,
   a. Types of services and activities offered,
   b. Client provisions,
   c. Fee policies,
   d. Target populations,
   e. Service delivery sites,
   f. Hours of operation.
2. Ensuring that the methadone treatment agency is operating in compliance with Department requirements;
3. Submitting required documentation to the Food and Drug Administration, Drug Enforcement Agency, state and local regulatory authorities for approval prior to initial operation of a methadone treatment program and which shall include:
   a. Organizational structure of the program;
   b. Program sponsor or administrator for each service site, if applicable;

c. Medical Director with feasibility statement if the physician assumes responsibility for more than one program;
d. Notification of each service delivery site's participation within a central organization, if applicable;
e. Identification of the physical location of each service delivery site;
f. Determination if medication will be administered or dispensed at the service site;
g. Operational statement of program services and activities;
h. Names and addresses of funding sources.

4. Appointing an administrator who shall have the authority and responsibility for the agency's operations and provision of methadone or methadone-like treatment services;
5. Appointing a medical director who shall have the authority and responsibility for the agency's medical services and treatment of narcotic addiction with a narcotic drug as performed by the methadone or methadone-like treatment agency in compliance with and regulated by federal, state, and local laws;
6. Notifying the Department, FDA, DEA, and all state and local regulatory authorities of deletion of a service site in which medication is administered or dispensed three weeks prior to the deletion;
7. Notifying the Department, FDA, DEA, and all state and local regulatory authorities of any addition or deletion of service sites which provide services other than administering or dispensing medication not less than 30 days prior to the deletion;
8. Allowing inspections by duly authorized employees of the Department, Federal Drug Administration (FDA), Drug Enforcement Administration (DEA), and the National Institute on Drug Abuse;
9. Complying with all federal and state reporting requirements relevant to methadone.

C. The provisions in this Article shall not apply to:
1. Agencies on military bases or those owned or operated by Indian tribes and located upon federally designated reservations.
2. Programs operated directly by the Veterans' Administration or any other department or agency of the United States.
3. Private offices and clinics of private practitioners who are licensed or certified under A.R.S. Title 32, but who are not responsible to a board of directors and who do not employ or contract with others to deliver behavioral health services.

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R9-20-1803. Administration

A. The administrator shall be responsible for the management of the agency's administrative program operations and shall:
1. Establish, maintain, and enforce the agency's policies and procedures;
2. Appoint a clinical director who shall supervise the provision of methadone treatment services;
3. Establish written personnel policies and procedures describing the duties, responsibilities, and qualifications of personnel;
4. Establish standards that govern the ethical conduct of personnel;
5. Appoint professional staff and supporting personnel to provide methadone treatment services;
6. Ensure staff orientation, training, and development and supervision;
7. Ensure that agency, program, and client records are maintained in one central location and available to the Department;
8. Ensure that personnel records are maintained and include signed and dated job descriptions, personnel qualifications pursuant to R9-20-309 and documentation of orientation and annual continuing education and training pursuant to R9-20-308;
9. Ensure that clients receive a current schedule of fees prior to providing services;
10. Ensure that client rights, client records, and client confidentiality are maintained pursuant to 42 CFR 2, October 1, 1992, which is incorporated herein by reference and on file with the Office of the Secretary of State, and R9-20-201;
11. Ensure that one or more staff members has a valid driver's license at all times whenever clients are present in the agency or on supervised outings; and
12. Ensure that a ratio of one full-time equivalent counselor to each 60 clients is maintained.

B. The medical director shall be responsible for the management of the agency's medical services and shall:
1. Ensure that the agency is in compliance with all federal, state, and local laws and regulations regarding medical treatment of narcotic addiction.
2. Authorize or designate, in writing, an acting physician licensed pursuant to A.R.S. Title 32, Chapter 13 or 17, to assume responsibilities for the agency's medical treatment in the medical director's absence.
3. Ensure that evidence of current physiologic dependence, length and history of addiction, or exceptions to criteria for admission are documented in the client's record before the client receives the initial dose.
4. Ensure that a medical evaluation, including a medical history, has been taken and a physical examination has been completed before the client receives the initial dose.
5. Ensure that a tuberculin - Mantoux skin test or chest x-ray and rapid Plasma Reagent Serology Test have been performed and reviewed, as clinically indicated.
6. Ensure that laboratory studies which are performed and reviewed, as clinically indicated, including the following:
   a. Complete blood count and differential;
   b. Routine and microscopic urinalysis;
   c. Liver functions profile;
   d. Hepatitis B surface antigen testing;
   e. When clinically indicated, an EKG;
   f. When appropriate, pregnancy test and a Pap test; and
   g. Other tests when clinically indicated.
7. Ensure that the following medical orders are signed or countersigned:
   a. Initial admission medication orders,
   b. Changes in medication orders,

c. All changes in the frequency of take-home medication, and
d. Prescriptions of additional take-home medication for emergency situations.

8. Review and countersign treatment plans not less than annually.
9. Ensure that justification is recorded in the client's record for reducing the frequency of clinic visits when:
   a. Drug ingesting is observed,
   b. Additional take-home medication is provided under exceptional circumstances,
   c. There is a physical disability, and
   d. Medication is prescribed for physical or emotional problems.
10. Ensure that drug dispensing records for each client are maintained, noting date, quantity, and batch or code marks of the drug dispensed, and are retained for a period not less than three years from the date of dispensing.
11. Ensure that the DEA-required security standards for the distribution and storage of controlled substances are maintained for drug stocks including the manner in which drugs are administered and dispensed.

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R9-20-1804. Client Records for Methadone or Methadone-like Treatment Programs

A. In addition to the requirements specified in R9-20-406 (A), a methadone or methadone-like treatment program shall comply with the requirements of this rule.

B. The client record shall also contain:
1. A copy of FDA-2635 "Consent to Methadone Treatment" form, which is attached as Exhibit A, or FDA-approved methadone-like treatment consent form, signed and dated by the client and responsible party, if applicable;
2. The date of each visit in which the client receives medication(s) with any take-home medications and respective date noted;
3. The results of each test or analysis for drugs;
4. Any physical or psychological disability;
5. The type of rehabilitative and counseling efforts employed; and
6. An annual evaluation of the client's progress.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1805. Program Approval

Each methadone or methadone-like treatment agency or service delivery site, whether an outpatient facility or a private practitioner, shall submit applications to the FDA and the Department, respectively, and shall require the approval of both agencies prior to initial operation.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1806. Admission and Discharge Criteria

A. The agency shall develop and put into effect written policies and procedures that address the agency's admission and discharge criteria and meet the requirements of this rule.

B. There shall be detailed written admission criteria to assist prospective clients and referring agencies to understanding the following admission policies:
1. It shall be the responsibility of the program sponsor or administrator to accept for admission clients whose needs do not exceed the agency's program capabilities and qualifications or the range of services for which the agency is licensed.
2. There shall be a description of conditions under which a client will be immediately admitted, put on waiting list, denied admission, or referred to another agency.
3. The client shall always report to the same treatment facility unless prior approval is obtained from the administrator for treatment at another program. Such an approval and its reasons shall be noted in the client's record.
4. It shall be the responsibility of the program sponsor or administrator to ensure that all relevant facts concerning the use of the narcotic drug used by the program are clearly explained to the client. Each client shall indicate full knowledge and understanding of the information by the client's dated signature and that of the responsible party, if applicable, on the FDA-2635 "Consent to Methadone Treatment" form which is attached as Exhibit A or any related methadone-like treatment consent form.
5. For clients under the age of 18, a parent, legal guardian, or responsible adult designated by the Department shall sign the FDA-2635 "Consent to Methadone Treatment" form which is attached as Exhibit A.

C. Admission to a program shall depend upon the history of addiction and current physiologic dependence.
1. A person may be admitted as a client for a maintenance program only if a program physician determines that the person:
   a. Is currently physiologically dependent upon a narcotic drug and became physiologically dependent at least one year before seeking admission for maintenance treatment; or

b. Was addicted, continuously or episodically, for most of the year immediately before seeking admission to the program.

2. In the case of a person for whom the exact date on which physiological addiction began cannot be ascertained, the admitting physician may, in the physician's clinical judgment, admit the person to maintenance treatment.

3. The program physician or a designated behavioral health professional, who is supervised by the physician, shall record in the client's record the criteria used to determine the client's current physiologic dependence and history of addiction.

4. The program physician shall sign, date, and record a statement that all the documented evidence to support a one-year history of addiction and the current physiologic dependence has been reviewed and that, in program physician's clinical judgment, the client fulfills the requirements for admission to maintenance treatment. The program physician shall complete and record the statement before the program administers any methadone to the client.

D. The admission criteria set forth in R9-20-1806(C) shall not apply to the following:

1. A person who has resided in a penal or chronic-care institution for one month or longer may be admitted to maintenance treatment within 14 days before release or discharge, or within six months after release, from such an institution without documented evidence to support findings of physiological dependence, provided the person submits evidence which indicates that the person would have been eligible for admission before the individual was incarcerated or institutionalized and, in the clinical judgment of a program physician, treatment is medically justified. The following documentation shall be maintained in the client record:
   a. Evidence of the prior residence in a penal or chronic-care institution,
   b. Criteria used to determine the physiological dependence findings,
   c. A dated signature by the admitting physician of physiological dependence evidence before the initial dose is admitted to the client, or
   d. Psychological dependence findings which are documented by a behavioral health professional shall be signed and dated by the admitting physician within 72 hours of administration of the initial dose to the client.

2. Pregnant clients. Pregnant clients, regardless of age, who have had a documented narcotic dependency, may be placed on a maintenance regimen.
   a. Agencies providing maintenance services to pregnant clients shall comply with R9-20- 1806(D)(1)(b) through (d).
   b. When a maintenance program cannot provide direct prenatal care for pregnant clients in treatment, the program shall establish a system for informing the clients of the publicly or privately funded prenatal care opportunities available.
   c. When the maintenance program cannot provide such services, and if there are no publicly or privately funded prenatal referral opportunities available, or the client cannot afford them or refuses them, then the program shall, at a minimum, offer her basic prenatal instruction on maternal, physical, and dietary care as part of its counseling service.
   d. Counseling and other appropriate record shall be required to reflect the nature of the prenatal support provided by the program.
   e. When the client is referred for prenatal services, the physician to whom she is referred shall be notified that she is in maintenance treatment in accordance with 42 CFR 2, October 1, 1992, which is incorporated herein by reference and on file with the Office of the Secretary of State.
   f. If a pregnant client refuses direct treatment or appropriate referral for treatment, the program physician shall have the client acknowledge in writing that she had opportunity for this treatment but refuses it.
   g. Following the birth of a client's child, the program physician, in accordance with 42 CFR 2, October 1, 1992, which is incorporated herein by reference and on file in the Office of the Secretary of State, shall request from the hospital to which a client was referred, a summary of the delivery and treatment outcome for the client and the offspring. If no response is received, the program physician shall document that such a request was made.
   h. Within three months after termination of pregnancy, the physician shall enter an evaluation of the client's treatment state and make a recommendation as to whether she should remain in the maintenance program or be detoxified.
   i. Dosage levels shall be maintained at the optimum effective dose. The physician shall be responsible for ensuring that each female client is fully informed of the possible risks to her or to her unborn child from continued use of, or withdrawal from, methadone dispensed by the program.

3. Previously treated clients. Clients who have received maintenance treatment may be readmitted to a program without evidence to support findings of current physiologic dependence for up to two years after discharge.

E. Limitations to admission for treatment of clients under 18.

1. A person under 18 shall have had two documented attempts at short-term detoxification or drug-free treatment to be eligible for maintenance treatment.

2. A one-week waiting period shall be required after a detoxification attempt. The physician shall then document in the client's record that the client continues to be or is again physiologically dependent on narcotic drugs.

3. In order to be admitted to a maintenance treatment program, persons under 18 years of age shall have a parent, legal guardian, or responsible adult designated by the state to complete and sign the FDA-2635 "Consent to Methadone Treatment" form which is attached as Exhibit A or FDA-approved methadone-like treatment consent form.

F. If, in the clinical judgment of the medical director, a particular client would not benefit from treatment with a narcotic drug, the client may be refused such treatment even if the client meets the admission standards.

G. Readmission Criteria:

1. There shall be a detailed written readmission criteria to assist a client in understanding requirements for readmission.

2. If a client misses methadone medications for two weeks or more without notifying the program, the program shall terminate. If the client does return for care and is accepted into the program, this shall be considered a readmission and shall be entered in the client's record.

H. Agencies providing methadone maintenance or methadone-like treatment services shall discharge clients in accordance with R9-20-401(C).

I. Discontinuation of methadone use:
1. Involuntary termination from treatment.
   a. The administrator shall be responsible for developing a written policy establishing criteria for involuntary termination from treatment.
   b. A copy of this policy shall be posted in a conspicuous area accessible to all clients.
   c. Understanding of the involuntary termination policy and procedure shall be verified by the dated signature of the client or designated representative on a form provided by the program.
   d. Under the involuntary termination policy, information about the client shall be kept confidential in accordance with 42 CFR 2, October 1, 1992, which is incorporated herein by reference and on file in the Office of the Secretary of State.
2. Voluntary withdrawal from methadone use:
   a. The determination to withdraw voluntarily from methadone shall be the decision of the client and the clinical judgment of the physician.
   b. Upon reaching a drug-free state, the client may remain in the program for as long as the treating physician determines necessary to ensure client stability in a drug-free state.
   c. The frequency of required program visits for drug-free clients may be adjusted at the discretion of the medical director.

J. Multiple Enrollments: To discourage drug dependent persons from enrolling in more than one methadone treatment program, drugs shall not be administered to a client who is currently receiving drugs from another program.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency errors in subsections (D)(1)(d) and (D)(2) corrected pursuant to letter received in the Office of the Secretary of State October 8, 1993 (Supp. 93-4). Agency errors in subsections (D)(1)(d), (D)(2), (E)(2) and (J) corrected pursuant to letter received in the Office of the Secretary of State October 19, 1993 (Supp. 93-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1807. Treatment Planning

Agencies providing methadone treatment services shall conduct treatment planning in accordance with R9-20-404(A) through (H).
1. A comprehensive methadone or methadone-like service agency shall develop individual client treatment plans which shall be reviewed and updated by the assigned behavioral health paraprofessional, behavioral health technician, or behavioral health professional staff when goals or objectives are accomplished, when additional client deficits that need intervention are identified, or at least every 90 days.
2. Short-term detoxification service agencies shall develop individual client treatment plans which shall be reviewed at least weekly.
3. Long-term detoxification service agencies shall develop individual client treatment plans which shall be reviewed at least every 30 days.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Punctuation error corrected pursuant to letter received in the Office of the Secretary of State October 19, 1993 (Supp. 93-4).

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R9-20-1808. Drug Testing

A. The administrator shall ensure that an initial drug screening test is completed for each prospective client.

B. After admission, the testing shall be performed on each client no less than:
1. Eight additional random tests during the first year in maintenance treatment; and
2. Quarterly random tests on each client for each subsequent year, except that a random test is performed monthly on each client who receives a six-day supply of take-home medication.

C. When a sample is collected from each client for testing, it shall be completed in a manner that minimizes the opportunity for falsification.

D. Each test shall be analyzed for opiates, methadone, amphetamines, cocaine, barbiturates, benzodiazepines.

E. A laboratory that performs testing required under this regulation shall hold a current license issued by the Office of State Laboratory Licensure and Certification.

F. If a program wishes to change a laboratory used for such testing, the program shall provide to the Department evidence that the change is approved by the FDA.

G. Test results shall not be the sole criteria utilized to discharge a client from treatment but shall be used as a guide to change treatment approaches. Test results used shall be definitive rather than presumptive.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-1809. Emergency Initial Medication Administration Services

The medical director or other authorized physicians may, upon review and with medical and clinical judgment, provide a client with an initial dose of methadone prior to the initial physical only in the situation in which the client is a woman who has been determined to be pregnant. Opiate withdrawal does not constitute an emergency.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-1810. Health Care Professionals

Behavioral health professionals, employed by a methadone treatment or a methadone-like treatment program may perform functions which are ordinarily performed by the medical director, if it is permitted by law and if those functions are delegated by the medical director. All records shall be properly countersigned by the medical director or a licensed physician.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency error corrected pursuant to letter received in the Office of the Secretary of State October 19, 1993 (Supp. 93-4).

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R9-20-1811. Staff Authorized to Dispense or to Administer Narcotic Drugs

A. Methadone may be dispensed only by a physician licensed pursuant to A.R.S. Title 32 and registered under the appropriate state and federal laws to order narcotic drugs for clients, or by an agent of the physician supervised by or under the order of the physician.

B. The physician shall be responsible for the amounts of methadone administered or dispensed and shall record and countersign all changes in dosage schedule.

C. Staff authorized to administer methadone shall be licensed as a:

1. Licensed practical nurse,
2. Registered nurse,
3. Pharmacist,
4. Nurse practitioner,
5. Physician assistant, or
6. Physician.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Agency error in subsection (C)(5) corrected pursuant to letter received in the Office of the Secretary of State October 19, 1993 (Supp. 93-4).

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R9-20-1812. Administration of Methadone

A. Methadone treatment programs shall administer or dispense in the oral liquid form.

B. The oral dosage shall be formulated in such a way as to reduce its potential for parenteral abuse.

C. The physician or designee shall prescribe the initial dose of methadone and shall adjust the dose to the narcotic tolerance of the client. On admission and subsequent observation:

1. For a heavy user of heroin, staff may administer initial dose of 15 to 30 milligrams of methadone with additional increments four to eight hours later.
2. If the symptoms of abstinence continue, the physician or designee may administer an additional five to ten milligram dose, as needed.
3. The physician or designee shall adjust the dosage, as individually tolerated and required, but shall not exceed 100 milligrams per day unless medically indicated or prior FDA approval is obtained.
4. The physician or designee shall document the dosage exception in the client's record.

D. Hospitalized clients under the care of a physician shall be permitted to receive methadone in parenteral form upon written approval by the attending physician.

E. Take-home medication shall be labeled and shall be packaged in special packaging as required by 16 CFR 1700.14, which in incorporated herein by reference and on file in the Office of the Secretary of State and in accordance with the Poison Prevention Packaging Act to reduce the chances of accidental ingestion. The label shall include the following information:

1. Treatment center's name, address, and telephone number;
2. Prescription identification number;
3. Physician's name;
4. Client's name;
5. Directions for ingestion;
6. Name of medication;
7. Dosage in milligrams;
8. Date;
9. Warning: "not for injection" or "for oral use only"; and
10. Pharmacist's initials.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Ari-

zona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-20-1813. Take-home Medication

A. Take-home medication may be given when, in the clinical judgment of the physician, the client is responsible to handle narcotic drugs. The physician or designated staff member shall record the reasons for the decision in the client's clinical record. Upon entry by designated staff, a physician shall review, countersign, and date the information in the client's record.

B. In determining whether or not a client is responsible to handling narcotic drugs, the physician shall consider the following:
1. Absence of recent abuse of drugs, narcotic or non-narcotic, including alcohol;
2. Regularity of clinic attendance;
3. Absence of serious behavioral problems at the clinic;
4. Absence of known recent criminal activity;
5. Stability of the client's home environment and social relationships;
6. Length of time in maintenance treatment;
7. Whether the take-home medication can be safely stored within the client's home; and
8. Rehabilitative benefit to the client derived from decreasing the frequency of clinic attendance versus the potential risks of diversion.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-1814. Take-home Requirements

A. A client shall not be eligible for weekend take-home privileges until completion of three months of treatment. A physician may, based on clinical judgment, deny or rescind the take-home privileges of the client.

B. Take-home requirements for maintenance treatment:
1. Clients shall come to the clinic for observation daily or six days a week for a period of no less than three months.
2. Following a period of not less than three months of continuous treatment, the physician or designee shall determine if a client may be permitted to reduce clinic attendance to five times weekly. The physician or designee shall utilize agency criteria to make the determination, which shall include, at a minimum, whether the client demonstrates the following:
   a. Adherence to program rules,
   b. Substantial progress in rehabilitation,
   c. Responsible handling of narcotic drugs, and
   d. Rehabilitative progress would be enhanced.
3. Following a period of not less than six months of continuous treatment, the physician or designee shall utilize the criteria listed in R9-20-1814(B)(2) to determine if a client may be permitted to reduce clinic attendance to three times weekly. The client may receive no more than a two-day take-home supply of medication.
4. If, after two years of continuous treatment, a client has complied with all the requirements of R9-20-1814(B)(2), the physician or designee may permit the client to reduce clinic attendance to twice weekly. The client may receive no more than a three-day supply of medication.
5. The physician or designee may permit the client to reduce clinic attendance to once weekly only when medical judgment has determined this to be appropriate. Documentation of the medical judgment shall be entered into the client record.
   a. If a client receiving a six-day supply of take-home medication based on the medical exception as indicated in R9-20-1814(D)(2) is absent without an excuse or misses a scheduled appointment for medication or counseling, without authorization from the program staff, the physician shall increase the frequency of the client's clinic attendance until a minimum of three consecutive monthly tests that give results that are neither positive for morphine-like drugs, except from the narcotic drug administered or dispensed by the program, or other drugs of abuse, nor negative for the narcotic drug administered or dispensed by the program, and until the client is determined by a physician to be responsible in handling narcotic drugs.
   b. If a client receiving a six-day supply of take-home medication has a test which is confirmed to be positive for morphine-like drugs or other drugs of abuse, or negative for the narcotic drug administered or dispensed by the program, the physician shall:
      i. Increase the frequency of the client's clinic attendance for observation to a minimum of twice weekly.
      ii. Limit the client to no more than a three-day take-home supply of medication until a minimum of three consecutive monthly tests obtained from the client are neither positive for morphine-like drugs or other drugs of abuse, or negative for the narcotic drug administered or dispensed by the program, and the physician again determines that the client is responsible in handling narcotic drugs.
6. The nurse administering medication shall observe each client whose daily dose is above 100 milligrams ingesting the drug a minimum of six days a week, irrespective of the time of treatment, unless the program has received prior approval from the FDA.

C. Time spent by the client in more than one program in continuous treatment is counted toward the number of years of treatment for the determination of take-home privileges.

D. Temporarily reduced take-home schedule requirements.
1. A physician may permit a client a temporarily reduced schedule upon a finding that the client is responsible for the handling of narcotic drugs and if, in the clinical judgment of the physician, the client meets one of the following conditions:
   a. A client has a physical disability which interferes with the ability to conform to the applicable mandatory schedule.
   b. A client, because of exceptional circumstances such as illness or personal family crisis is unable to conform to the applicable mandatory schedule.
   c. A client who, after three years of continuous treatment, has continued to meet the requirements

addressed in R9-20-1813 and R9-20-1814. Only those clients who have been permitted to reduce clinic attendance to once weekly and who continue to comply with R9-20-1813 and R9-20-1814 may maintain this schedule.

d. A client's capacity to continue current employment is dependent on a reduced program attendance schedule. The physician or designee may grant the client only that privilege level which immediately precedes the client's current privilege level; a client who currently maintains biweekly privileges may be granted a six-day take-home supply of medication. A client shall receive such an exception only once within a one-year period and only for a duration not to exceed 90 days.

2. The physician shall review, countersign, and date in the client's record the decision to permit the temporary take-home privileges.
3. A client shall not be given more than one consecutive, two-week supply of narcotic drugs within a one-year period.

E. The Medical Director shall permit each client one extra take-home dose per visit and one less clinic visit per week to permit clients not to have to attend the clinic on an official state holiday or administrative clinic closure.

Historical Note
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R9-20-1815. Short-term Detoxification Treatment Requirements

A. Take-home medication shall not be allowed during 30-day short-term detoxification.
B. A history of one-year physiologic dependence shall not be required for admission to short-term detoxification.
C. Clients who have been determined by the program physician to be currently physiologically narcotic dependent may be placed in short-term detoxification treatment regardless of age.
D. No drug test shall be required for participation in short-term detoxification treatment except for the initial drug screening or analysis.
E. A primary counselor shall be assigned to monitor a client's progress toward the goal of short-term detoxification treatment, but an initial treatment plan and periodic treatment plan evaluations required for maintenance clients are not necessary for short-term detoxification treatment.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-1816. Long-term Detoxification Treatment Requirements

The Medical Director shall ensure that methadone administered in long-term detoxification treatment is on a regimen designed to reach a drug-free state in 31 to 180 days or less. All requirements for maintenance treatment apply to long-term detoxification treatment.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-20-1817. Hospital Use of Methadone for Detoxification Treatment

A. A hospital may administer methadone in either oral or parenteral form.
B. A hospital may administer or dispense methadone only for the detoxification treatment of narcotic addiction.
C. Any hospital which has received approval from the FDA to provide methadone treatment may serve as a temporary treatment program when an approved program has been terminated or there is no other facility immediately available in the area.
D. The hospital shall maintain accurate records showing dates, quantity, and batch or code marks of the drug used for client treatment. The hospital shall retain records for a minimum of three years.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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Exhibit A. Consent to Methadone Treatment

DEPARTMENT OF HEALTH AND HUMAN SERVICES **PUBLIC HEALTH SERVICE** **FOOD AND DRUG ADMINISTRATION** **CONSENT TO METHADONE TREATMENT** *(Provisions of this form may be modified to conform to any applicable state law)*	DATE
NAME OF PATIENT	
NAME OF PRACTITIONER EXPLAINING PROCEDURES	
NAME OF PROGRAM MEDICAL DIRECTOR	

I hereby authorize and give my voluntary consent to the above named Program Medical Director, and/or any appropriately authorized assistants he may select, to administer or prescribe the drug methadone as an element in the treatment for my dependence on heroin or other narcotic drugs.

The procedures necessary to treat my condition have been explained to me and I understand that it will involve my taking daily dosages of methadone, or other drugs, which will help control my dependence on heroin or other narcotic drugs.

It has been explained to me that methadone is a narcotic drug which can be harmful if taken without medical supervision. I further understand that methadone is an addictive medication and may, like other drugs used in medical practice, produce adverse results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, but I still desire to receive methadone due to the risk of my return to the use of heroin or other drugs.

The goal of methadone treatment is total rehabilitation of the patient. Eventual withdrawal from the use of all drugs, including methadone, is an appropriate treatment goal. I realize that for some patients methadone treatment may continue for relative long periods of time but that periodic consideration shall be given concerning my complete withdrawal from methadone use.

I understand that I may withdraw from this treatment program and discontinue the use of the drug at any time and I shall be afforded detoxification under medical supervision.

I agree that I shall inform any doctor who may treat me for any medical problem that I am enrolled in a narcotic treatment program, since the use of other drugs in conjunction with methadone may cause me harm.

I also understand that, during the course of treatment, certain conditions may make it necessary to use additional or different procedures than those explained to me. I understand that these alternate procedures shall be used when in the Program or Medical Director's professional judgment it is considered advisable.

(See reverse of this sheet for additional consent elements)

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FEMALE PATIENTS OF CHILD-BEARING AGE	PATIENTS UNDER 18 YEARS OF AGE
To the best of my knowledge, I ____ am ____ am not pregnant at this time. Besides the possible risks involved with the long-term use of methadone, I further understand that, like heroin and other narcotic drugs, information on its effects on pregnant women and on their unborn children is at present inadequate to guarantee that it may not produce significant or serious side effects. It has been explained to me and I understand that methadone is transmitted to the unborn child and will cause physical dependence. Thus, if I am pregnant and suddenly stop taking methadone, I or the unborn child may show signs of withdrawal which may adversely affect my pregnancy or the child. I shall use no other drugs without the Medical Director or his assistants' approval, since these drugs, particularly as they might interact with methadone, may harm me or my unborn child. I shall inform any other physician who sees me during my present or any future pregnancy or who sees the child after birth, of my current or past participation in a narcotic treatment program in order that he/she may properly care for my child and me. It has been explained to me that after the birth of my child I should not nurse the baby because methadone is transmitted through the milk to the baby and this may cause physical dependence on methadone in the child. I understand that for a brief period following the birth, the child may show temporary irritability or other ill effects due to my use of methadone. It is essential for the child's physician to know of my participation in a narcotic treatment program so that he/she may provide appropriate medical treatment for the child. All of the above possible effects of methadone have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of the drug to assure complete safety to my child. With full knowledge of this, I consent to its use and promise to inform the Medical Director or one of his/her assistants immediately if I become pregnant in the future.	The patient is a minor, _____ years of age, born _____. The risks of the use of methadone have been explained to (me/us) and (I/we) understand that methadone is a drug on which long-term studies are still being conducted and that information on its effects in adolescents is incomplete. It has been explained to (me/us) that methadone is being used in the minor's treatment only because the risk of (his/her) return to the use of heroin is sufficiently great to justify this treatment. (I/We) declare that participation in the narcotic treatment program is wholly voluntary on the part of both the parent(s)/guardian(s) and the patient and that methadone treatment may be stopped at any time on (my/our) request or that of the patient. With full knowledge of the potential benefits and possible risks involved with the use of methadone in the treatment of an adolescent, (I/we) consent to its use upon the minor, since (I/we) realize that otherwise (he/she) shall continue to be dependent upon heroin or other narcotic drugs.

I certify that no guarantee or assurance has been made as to the results that may be obtained from methadone treatment. With full knowledge of the potential benefits and possible risks involved, I consent to methadone treatment, since I realize that I would otherwise continue to be dependent on heroin.

SIGNATURE OF PATIENT	DATE OF BIRTH	DATE
SIGNATURE OF PARENT(S) OR GUARDIAN(S)	RELATIONSHIP	DATE
SIGNATURE OF WITNESS		DATE

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ARTICLE 19. LEVEL II RURAL COUNTY DETOXIFICATION SERVICES PILOT PROGRAM

Part A. Pilot Program Requirements

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings.

R9-20-A1901. Definitions

In this Article, unless the context otherwise requires:

1. "Behavioral health professional" means the same as defined in R9-20-101(10).
2. "Behavioral health services" means the same as defined in R9-20-101(12).
3. "Client" means an individual who is admitted into an agency participating in the Level II rural county detoxification services pilot program.
4. "Governing authority" means the same as defined in A.R.S. § 36-401(A)(16).
5. "Level II behavioral health facility" or "agency" means, for purposes of Laws 1995, Ch. 275, § 10, a facility licensed pursuant to Article 7 of this Chapter or an unlicensed facility approved pursuant to this Article to provide pilot program detoxification services.
6. "Level II rural county detoxification services pilot program" means those agencies which are participating to provide detoxification services, either directly or by contract, to individuals in accordance with Laws 1995, Ch. 275, § 10.
7. "Manager" means the individual designated by the governing authority to act in its behalf in the overall on-site management of the agency.
8. "Paraprofessional counseling" means treatment activities provided by individuals who are not licensed behavioral health professionals.
9. "Supervision" means that a program's staff is available on a 24-hour-per-day basis to provide detoxification services and to monitor the health and safety of the program's clients.
10. "Treatment plan" means the written statement of methodologies of care and provision of behavioral health services prepared by agency staff to meet the client's needs as identified in the assessment, evaluation, and diagnosis processes.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12, effective March 13, 1996 (Supp. 96-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings.

R9-20-A1902. Level II Rural County Detoxification Services Pilot Program

A. A Level II behavioral health facility or unlicensed facility which proposes to provide detoxification services in accordance with Laws 1995, Ch. 275, § 10 shall be located only in counties having a population of 500,000 persons or less according to the most recent United States decennial census.

B. An unlicensed facility which desires to participate in the Level II rural county detoxification services pilot program shall be approved in accordance with Part B of this Article.

C. All Level II rural county detoxification services pilot program participating agencies shall comply, at a minimum, with the program requirements set forth in R9-20-B1902 through R9-20-B1908.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12, effective March 13, 1996 (Supp. 96-1).

Part B. Rural County Program Approval

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings.

R9-20-B1901. Approval Requirements

A. An unlicensed program seeking to participate in the Level II rural county detoxification services pilot program as provided by Laws 1995, Ch. 275, § 10 shall comply with the requirements of R9-20-107 through R9-20-201, R9-20-308, R9-20-309 (excluding subsection (A)(7)), R9-20-405(A), and R9-20-505(F).

B. An unlicensed program applying for initial approval or reapproval for participation in the Level II rural county detoxification services pilot program shall submit to the Director evidence of compliance with these rules and the following additional information:

1. Complete information regarding ownership, physical plant, staff, records, and services;
2. Annual sanitation inspection report; and
3. Annual fire inspection from the fire authority having jurisdiction.

C. An applicant for initial approval, construction of a new facility, or alteration of an existing facility shall also submit the following documents:

1. Site plan of the facility drawn to scale and dimension showing property lines, buildings, roads, drives, parking, walkways, building entrances, and exits;
2. Floor plan of the facility drawn to scale and dimension showing entire floor plan, rooms, service and program areas, corridors, stairs, entry, exits, fire protection design, and systems;
3. Code information including statement and calculations indicating construction type, occupancy type, occupant load, fire sprinkler, fire alarm, and fire detection requirements; and
4. Certificate of occupancy, fire inspection, and approval report and clearance from the local authority having jurisdiction if an existing building is utilized as an agency, or a copy of the building permit and zoning clearance from the local authority having jurisdiction if a center is newly constructed or an alteration is made to an existing center.

D. An approval shall be valid for a period of 1 year from the date of issuance for the owner, name, location, and number of beds specified on the application.

E. An applicant shall file a request for approval or re-approval within 60 to 120 days before anticipated operation or the expiration date of the current approval.

F. The Director may issue or renew an approval if an applicant meets all of the following requirements:
1. Is in substantial compliance with these rules,
2. Carries out a plan acceptable to the Director to eliminate any noncompliance with the standards for approval set forth in these rules, and
3. Has a letter of agreement or contract with a regional behavioral health authority to participate in a Level II rural county detoxification services pilot program in accordance with this Article and Laws 1995, Ch. 275, § 10.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12, effective March 13, 1996 (Supp. 96-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings.

R9-20-B1902. Management

A. An agency shall have a governing authority which shall consist of 1 or more persons responsible for organizing and managing the agency and adopting policies and procedures that govern the provision of detoxification services to clients.

B. The governing authority of the agency shall designate a manager who shall have, at a minimum, 1 of the following:
1. Bachelor's degree in a behavioral health or health-related field;
2. Bachelor's degree in any field, plus 1 year of work experience in behavioral health services delivery; or
3. High school diploma or general education diploma (GED) and a minimum of 4 years of behavioral health education or work experience involving detoxification, or a combination of the 2.

C. The manager of an agency shall be responsible for establishing, implementing, and maintaining policies and procedures governing:
1. Client rights and responsibilities;
2. A fire and safety plan;
3. Residency arrangements for clients, including admission and discharge;
4. Client services, treatment, or care;
5. Client confidentiality;
6. Unauthorized entry to or exit from the program by clients, staff, or other individuals;
7. Medications administration;
8. Client nutrition;
9. Client record confidentiality, storage, transportation, and dissemination of identifying information;
10. Emergency treatment procedures; and
11. Annual review of the agency policies and procedures which shall be documented in writing and available to the Department for review.

D. The manager of an agency shall ensure that it operates on a 24-hour basis, including intake and placement. If a vacancy does not exist in the agency, the manager shall ensure that assistance and referral services are provided to individuals seeking care.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12, effective March 13, 1996 (Supp. 96-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings.

R9-20-B1903. Detoxification Services

A. The manager of an agency shall ensure the provision of the following detoxification services to each client:
1. A medical assessment performed by a physician licensed pursuant to A.R.S. Title 32, Chapters 13 and 17; a professional nurse licensed in accordance with A.R.S. Title 32, Chapter 15; or an emergency medical technician certified pursuant to A.R.S. Title 36, Chapter 21.1, within 72 hours of admission;
2. An assessment and development of a treatment plan within 24 hours of admission, including a determination of the need for medical care and transport to a hospital;
3. Chemical dependency assessment within 24 hours of admission;
4. Close observational assessment and regular monitoring of vital signs;
5. Twenty-four hour supervision and the ability to manage, either directly or by referral, a client's physiological manifestations and distress exhibited in the course of withdrawal from chemical dependency;
6. Supervised paraprofessional counseling or behavioral health professional counseling which may include individual, group, and family counseling and participation in motivational programs as indicated in the client's treatment plan, but which does not include peer and self-help groups;
7. Recreational, rehabilitation, or habilitation activities to involve the client in interpersonal interactions;
8. Referral to other social services or treatment agencies; and
9. Transportation for emergencies. Telephone numbers of ambulance services shall be available to all staff members on duty.

B. An agency shall transfer a client who requires treatment beyond the scope of the agency to another behavioral health facility or a medical facility. The agency shall assist the client in securing necessary transportation.

C. The manager shall ensure that a treatment plan and necessary updates are prepared by agency staff for each client. The manager shall ensure that the treatment plan is followed by the agency while the client is in treatment.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12, effective March 13, 1996 (Supp. 96-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the

rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings.

R9-20-B1904. Staffing Requirements

The manager of an agency shall ensure that:

1. Staff is available to provide detoxification services and monitor the health and safety of each client at all times, and
2. At least 1 staff member who is certified in first aid and cardiopulmonary resuscitation and who has the education to counsel clients who are experiencing acute distress due to behavioral health issues shall be available at all times.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12, effective March 13, 1996 (Supp. 96-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings.

R9-20-B1905. Program Description

An agency shall provide a program description to each client upon admission. The program description shall describe the program's residence rules and services.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12, effective March 13, 1996 (Supp. 96-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings.

R9-20-B1906. Facility Physical Plant Standards

A. An agency shall provide 40 square feet per approved bed in the sleeping area of the facility for each client.

B. If a bunk bed is used for a client in the detoxification unit, an agency shall place a client in the lower bed of the bunk bed only for the 1st 48 hours after admission. An agency shall not place a client in the upper bed of a bunk bed until 48 hours after admission.

C. There shall be a separate dining area. The agency shall not use the dining area as a sleeping area.

D. An agency shall not exceed the number of beds for which the agency is approved to provide detoxification services.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12, effective March 13, 1996 (Supp. 96-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings.

R9-20-B1907. Recordkeeping

The manager of an agency shall ensure that the following records are maintained:

1. All required operating licenses, permits, and certificates;
2. Client file documentation which shall contain:
   a. Client identifying information;
   b. Name of an emergency contact;
   c. A list of the client's medication, if applicable;
   d. The client's initial assessment and evaluation;
   e. The client treatment plan and updates;
   f. Treatment or staffing summaries;
   g. Notation of contacts or referrals;
   h. Discharge summaries from the provider agency; and
   i. A forwarding address for the client, if available.
3. Reports of all inspections and reviews, including fire and sanitation reports, with documentation of all corrective actions taken.
4. Reports of quarterly fire drills.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12, effective March 13, 1996 (Supp. 96-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings.

R9-20-B1908. Fire and Safety

A. An agency shall maintain smoke detectors in working order near every sleeping and cooking area. Battery-powered smoke detectors may be utilized.

B. Fire drills shall be conducted on a quarterly basis. All clients and staff shall participate in fire drills.

C. The agency shall maintain a first-aid kit in the facility which is accessible to all staff.

D. A list of emergency numbers and poison centers' numbers shall be maintained near a telephone for easy access by staff and clients.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12, effective March 13, 1996 (Supp. 96-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings.

R9-20-B1909. Transfer to Another Classification

An unlicensed agency which is approved for purposes of participating in the Level II rural county detoxification services pilot program and which seeks to provide treatment services as a Level II behavioral health facility shall comply with the licensure requirements in Article 7 of this Chapter.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 275, § 12, effective March 13, 1996 (Supp. 96-1).

TITLE 9. HEALTH SERVICES

CHAPTER 21. DEPARTMENT OF HEALTH SERVICES
MENTAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

Title 9, Chapter 21 was adopted and amended by the Department of Health Services under the provisions of Laws 1992, Ch. 301, § 61, which provided for an exemption from the rulemaking process as specified in the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6, § 41-1001 et seq.). ***Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; The Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules. Because this Chapter contains rules which are exempt from the provisions of the Arizona Administrative Procedure Act, the Chapter is being printed on blue paper.***

Former Title 9, Chapter 21 renumbered to Title 18, Chapter 11.

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ARTICLE 1. GENERAL PROVISIONS

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-101. Definitions

A. In this Chapter, unless the context otherwise requires, the terms defined in A.R.S. § 36-501 shall have the meaning set forth in that Section.

B. In this Chapter, unless the context otherwise requires:

1. "Abuse" means, with respect to a client, the infliction of, or allowing another person to inflict or cause, physical pain or injury, impairment of bodily function, disfigurement or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal or untoward aggressive behavior. Such abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a client receiving behavioral health services under this Chapter. Abuse shall also include sexual misconduct, assault, molestation, incest, or prostitution of, or with, a client under the care of personnel of a mental health agency.
2. "Agency director" means the person primarily responsible for the management of an outpatient or inpatient mental health agency, service provider, regional authority or the deputy director of the division, or their designees.
3. "AHCCCSA" means the Arizona Health Care Cost Containment System Administration.
4. "ASH" means the Arizona State Hospital.
5. "Burden of proof" means the necessity or obligation of affirmatively proving the fact or facts in dispute.
6. "Case manager" means the person responsible for locating, accessing and monitoring the provision of services to clients in conjunction with a clinical team.
7. "Client" means an individual who is seriously mentally ill and is being evaluated or treated for a mental disorder by or through a regional authority.
8. "Client record" means the written compilation of information that describes and documents the evaluation, diagnosis or treatment of a client.
9. "Client who needs special assistance" means a client who has been:
   a. Deemed by a qualified clinician, case manager, clinical team, or regional authority to need special assistance in participating in the ISP or ITP process, which may include, but is not limited to:
      i. A client who requires 24-hour supervision;
      ii. A client who is, in fact, incapable of making or communicating needs but is without a court-appointed fiduciary; or
      iii. A client with physical disabilities or language difficulties impacting the client's ability to make or communicate decisions or to prepare or participate in meetings; or
   b. Otherwise deemed by a program director, the deputy director of the Division, or a hearing officer to need special assistance to effectively file a written grievance, to understand the grievance and investigation procedure, or to otherwise effectively participate in the grievance process under this Chapter.
10. "Clinical team" refers to the interdisciplinary team of persons who are responsible for providing continuous treatment and support to a client and for locating, accessing and monitoring the provision of mental health services. A clinical team consists of a psychiatrist, case manager, vocational specialist, psychiatric nurse, and other professionals or paraprofessionals, such as a psychologist, social worker, consumer case management aide, or rehabilitation specialist, as needed, based on the client's needs. The team shall also include a team leader who is a certified behavioral health supervisor under Laws 1992, Ch. 310.
11. "Community services" means community mental health services required to be provided under A.R.S. § 36-550 et seq. and includes, but is not limited to, clinical case management, outreach, housing and residential services, crisis intervention and resolution services, mobile crisis teams, day treatment, vocational training and opportunities, rehabilitation services, peer support, social support, recreation services, advocacy, family support services, outpatient counseling and treatment, transportation, and medication evaluation and maintenance.
12. "Condition requiring investigation" means, within the context of the grievance and investigation procedure set forth in Article 4 of this Chapter, an incident or condition which appears to be dangerous, illegal, or inhumane, including a client death.
13. "County Annex" means the Maricopa County Psychiatric Annex of the Maricopa Medical Center.
14. "Court-ordered treatment" means treatment ordered by the court under A.R.S. Title 36, Chapter 5.
15. "Court-ordered evaluation" means evaluation ordered by the court under A.R.S. Title 36, Chapter 5.
16. "Crisis services" or "emergency services" means immediate and intensive, time-limited, crisis intervention and resolution services which are available on a 24-hour basis and may include information and referral, evaluation and counseling to stabilize the situation, triage to an inpatient setting, clinical crisis intervention services, mobile crisis services, emergency crisis shelter services, and follow-up counseling for clients who are experiencing a psychiatric emergency.
17. "Dangerous" as used in Article 4 of this Chapter means a condition that poses or posed a danger or the potential of danger to the health or safety of any client.
18. "Department" means the Arizona Department of Health Services.
19. "Designated representative" means a parent, guardian, relative, advocate, friend, or other person, designated by a client or guardian who, upon the request of the client or guardian, assists the client in protecting the client's rights and voicing the client's service needs.
20. "Discharge plan" means a hospital or community treatment and discharge plan prepared pursuant to Article 3 of these rules.
21. "Division" means the Division of Behavioral Health Services of the Department.
22. "DSMI" means the latest edition of the "Diagnostic and Statistical Manual of Mental Disorders," edited by the American Psychiatric Association.
23. "Exploitation" means the illegal or improper use of a client or a client's resources for another's profit or advantage.

24. "Frivolous", as used in this Chapter, means a grievance that is devoid of merit. Grievances are presumed not to be frivolous unless the program director has good reason to believe that the grievance:
    a. Involves conduct that is not within the scope of this Chapter,
    b. Is impossible on its face, or
    c. Is substantially similar to conduct alleged in two previous grievances within the past year that have been determined to be unsubstantiated as provided in this Chapter.
25. "Generic services" means services other than mental health services for which clients may have a need and includes, but is not limited to, health, dental, vision care, housing arrangements, social organizations, recreational facilities, jobs, and educational institutions.
26. "Grievance" means a complaint regarding an act, omission or condition, as provided in this Chapter.
27. "Guardian" means an individual appointed by court order pursuant to A.R.S. Title 14, Chapter 5 or Title 36, Chapter 5, or similar proceedings in another state or jurisdiction where said guardianship has been properly domesticated under Arizona law.
28. "Hearing officer" refers to an impartial person designated by the director to hear a dispute and render a written decision.
29. "Human rights advocate" means the human rights advocates appointed by the director under R9-21-105.
30. "Human rights committee, means the human rights committee established under R9-21-106 by the Department or by a regional authority.
31. "Illegal" means, within the context of the grievance and investigation procedure set forth in Article 4 of this Chapter, an incident or occurrence which is or was likely to constitute a violation of a state or federal statute, regulation, court decision or other law, including the provisions of these Articles.
32. "Individual service plan" or "ISP" means the written plan for services to a client, prepared in accordance with Article 3 of this Chapter.
33. "Inhumane" as used in Article 4 of this Chapter means an incident, condition or occurrence that is demeaning to a client or which is inconsistent with the proper regard for the right of the client to humane treatment.
34. "Inpatient facility" means the Arizona State Hospital, the County Annex, or any other inpatient treatment facility licensed or funded by or through the Department to provide mental health services, including psychiatric health facilities, licensed psychiatric hospitals, licensed psychiatric units in general hospitals, and licensed inpatient or behavioral health facilities in jails.
35. "Inpatient treatment and discharge plan" or "ITDP" means the written plan for services to a client prepared and implemented by an inpatient facility in accordance with Article 3 of this Chapter.
36. "Likelihood of serious physical harm" means either
    a. A substantial and imminent risk that serious physical harm will be inflicted by a client upon himself, as evidenced by threats or attempts to commit suicide or to inflict physical harm on himself; or
    b. A substantial and imminent risk that serious physical harm will be inflicted by a client upon another as evidenced by previous behavior that has caused such harm or that places another person or persons in reasonable fear of sustaining such harm. Substantial and imminent risk shall be interpreted to include only those instances where there is the present ability to enact serious physical harm or where there is a realistic perception of such ability.
37. "Long-term view" means a planning statement that identifies, from the client's perspective, what the client would like to be doing for work, education, and leisure and where the client would like to be living for up to a three-year period. The long-term view is based on the client's unique interests, strengths, and personal desires. It includes predicted times for achievement.
38. "Mechanical restraint" means the use of any Article, device, or garment that restricts a client's freedom of movement or a portion of a client's body, and cannot be easily removed by the client, and is used for the purpose of confining the client's mobility but does not include such a device used for orthopedic or surgical reasons or other medical device necessary to allow a client to heal from a medical condition or to participate in a treatment program.
39. "Meeting" means an encounter or assembly of individuals which may be conducted in person or by telephone.
40. "Mental health agency" includes a regional authority, service provider, inpatient facility, or an agency licensed to conduct screening, evaluation and treatment under this Chapter.
41. "Mental health services" include community services and psychiatric hospitalization.
42. "Party" or "parties" as used in Articles 3 and 4 of these rules means the person filing a grievance under this Chapter, the agency director who issued any final resolution or decision of such a grievance, the person whose conduct is complained of in the grievance, any client or applicant who is the subject of the request or grievance, the legal guardian of client or applicant, and, in selected cases, the appropriate human rights committee.
43. "Pharmacological restraint" means the use of a psychopharmacologic drug for discipline of the person or convenience of the staff and not solely required to treat medical symptoms identified by staff and recorded in the person's medical record:
    a. In response to a likelihood of serious harm, or
    b. In such a manner as to unreasonably restrict a client's movement.
44. "Physical restraint" means the use of bodily force to restrict the client's freedom of movement but does not include the firm but gentle holding of a client for less than five minutes with no more force than necessary to protect the client or others from harm.
45. "PRN order" or "Pro re rata medication" means medication given as needed.
46. "Program director" means the person with the day-to-day responsibility for the operation of a programmatic component of a service provider, such as a specific residential, vocational, or case management program.
47. "Qualified clinician" means a behavioral health professional who is licensed or certified under A.R.S. Title 32, or a behavioral health technician who is supervised by a licensed or certified behavioral health professional.
48. "Region" means the geographical region designated by the Department in its contract with the regional authority.
49. "Regional authority" means the regional behavioral health authority under contract with the Department to organize and administer the delivery of mental health services to clients within a defined geographic area.

50. "Restraint" means physical, mechanical or pharmacological restraint.
51. "Seclusion" means restricting a client to a room or area through the use of locked doors or any other device or method which precludes a client from freely exiting the room or area or which a client reasonably believes precludes his unrestricted exit. In the case of an inpatient facility, confining a client to the facility, the grounds of the facility, or a ward of the facility does not constitute seclusion. In the case of a community residence, restricting a client to the residential site, pursuant to specific provisions of an individual service plan or court order, does not constitute seclusion.
52. "Seriously mentally ill" means a person 18 years of age or older who is either seriously mentally ill or chronically mentally ill as those terms are defined in A.R.S. § 36-550.
53. "Service provider" means an agency, inpatient facility or other mental health provider funded by or through, under contract or subcontract with, licensed by, certified by, approved by, registered with, or supervised by, the Department, or receiving funds under Title XIX, to provide mental health services.
54. "State Protection and Advocacy System" means the agency designated as the Protection and Advocacy System for individuals with mental illness, pursuant to 42 U.S.C. 10801-51.
55. "Title XIX" means Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq.
56. "Treatment team" means the multidisciplinary team of persons who are responsible for providing continuous treatment and support to a client who is a current resident of an inpatient facility.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-102. Applicability
With regard to the provision of mental health services to clients under A.R.S. Title 36 Chapter 5, this Chapter shall apply to the Department and to all mental health agencies funded by or through, under contract or subcontract with, licensed by, certified by, approved by, registered with, or supervised by, the Department or receiving funds under Title XIX, to provide mental health services. This Chapter shall not apply to the Arizona Department of Corrections.

Historical Note
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R9-21-103. Principles
The purpose of this Chapter is to implement Arizona's mental health program for clients under A.R.S. Title 36, Chapter 5. These rules shall be interpreted and enforced so as to ensure that all programs for mental health services provide:

1. Human dignity;
2. Respect for the client's individuality, abilities, needs, and aspirations without regard to the client's psychiatric condition;
3. Self-determination, freedom of choice and participation in treatment to the client's fullest capacity;
4. Freedom from the discomfort, distress and deprivation which arise from an unresponsive and inhumane environment;
5. Privacy, including the opportunity wherever possible to be provided clearly defined private living, sleeping and personal care spaces;
6. Humane and adequate support and treatment that is responsive to the client's needs, that recognizes that a client's needs may vary, and that is sufficiently flexible to adjust to a client's changing needs;
7. The opportunity to receive services which are adequate, appropriate, consistent with the client's individual needs, and least restrictive of the client's freedom;
8. The opportunity to receive treatment and services which are culturally sensitive in their structure, process and content;
9. The opportunity to receive services on a voluntary basis to the maximum extent possible and entirely if possible;
10. Integration of clients into their home communities through housing and residential services which are located in residential neighborhoods, which rely as much as possible on generic support services to provide training and assistance in ordinary community experiences, and which utilize specialized mental health programs that are situated in or near generic community services;
11. The opportunity to live in one's own home and the flexibility of a service system which responds to individual needs by increasing, decreasing and changing services as needs change;
12. The opportunity to undergo normal experiences, even though such experiences may entail an element of risk; provided, however, that a client's safety or well-being or that of others shall not be unreasonably jeopardized;
13. The opportunity to engage in activities and styles of living, consistent with the client's interests, which encourage and maintain the integration of the client into the community.

Historical Note
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R9-21-104. Computation of Time

In computing any period of time prescribed or allowed by this Chapter, the day of the act, event or default from which the designated period of time begins to run shall not be included. When the period of time prescribed or allowed is less than 11 days, intermediate Saturdays, Sundays and legal holidays shall not be included in the computation. When that period of time is 11 days or more, intermediate Saturdays, Sundays and legal holidays shall be included in the computation. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday or a legal holiday, in which event the period runs until the end of the next day which is not a Saturday, a Sunday or a legal holiday.

Historical Note

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R9-21-105. Office of Human Rights; Human Rights Advocates

A. The director shall establish an Office of Human Rights for clients within the Department. The office shall have its own chief officer appointed by the director. The chief officer shall report directly to the director and shall be responsible for the management and control of the office, as well as the hiring, training, supervision, and coordination of all Department human rights advocates.

B. The chief officer shall appoint at least one human rights advocate for each 2,500 clients in each region. Each region shall have at least one human rights advocate. The chief officer shall appoint at least one human rights advocate for ASH. All clients shall have the right of access to a human rights advocate in order to understand, exercise, and protect their rights. The human rights advocate shall advocate on behalf of clients and shall assist clients in understanding and protecting their rights and obtaining needed services. The human rights advocate shall also assist clients in resolving appeals and grievances under Articles 3 and 4 of this Chapter and shall coordinate and assist the human rights committees in performing their duties.

C. The human rights advocates shall be given access to:

1. All clients; and
2. Client records from a service provider, regional authority or the Department, except as prohibited by A.R.S. §§ 36-445 et seq., provided the advocate obtains written consent from the client and signs a written statement agreeing to adhere to all applicable laws regarding the confidentiality of such records.

D. Staff of inpatient facilities, regional authorities, and service providers shall cooperate with the advocate by providing relevant information, reports, investigations, and access to meetings, staff persons, and facilities except as prohibited by A.R.S. §§ 36-445 et seq., 36-107, 36-504, 36-507, 36-509, and 36-517.01, and the client's right to privacy.

E. The Office of Human Rights shall promptly distribute to all appropriate human rights committees copies of all reports received pursuant to this Chapter (e.g., reports regarding clients who need special assistance, allegations of mistreatment, denial of rights, restraint, and seclusion).

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-21-106. Human Rights Committees

A. The Department shall establish a human rights committee with statewide jurisdiction which shall advise the Director. In addition, each regional authority shall establish at least one regional human rights committee for each 2,500 clients in that region. ASH and each regional authority shall establish at least one human rights committee. Each ASH and regional human rights committee shall report to the statewide human rights committee regarding its policies and procedures and methods of operation.

B. Each human rights committee shall be composed of at least 7 and not more than 15 members. At least two members of the committee shall be clients or former clients, at least two members shall be relatives of clients, and at least three members shall have expertise in the area of psychology, law, medicine, or mental health services.

C. The director shall appoint the initial members to the statewide committee. The director of each regional authority shall appoint the initial members of each regional committee. Thereafter, the committees will select or remove their own members, pursuant to their own rules.

D. Each committee shall meet at least six times each year. Within three months of its formation, each committee shall establish written policies governing the committee's operations. These policies shall be consistent with this rule and shall set forth the terms of membership, quorum and attendance requirements, and procedures for conducting committee business. The adoption and amendment of the committee's policies shall be by a majority vote of the committee and shall be filed with the Division and, in the case of a regional committee, they shall also be filed with the regional authority.

E. No employee of the Department, regional authority or service provider may be a voting member of a committee.

F. Each committee shall, within its respective jurisdiction, provide independent oversight and review of:

1. Allegations of illegal, dangerous or inhumane treatment of clients;
2. Monthly reports filed with the committee under R9-21-203 and R9-21-204 concerning the use of seclusion,

restraint, abuse, neglect, exploitation, mistreatment, accidents and injuries;
3. The provision of services to clients identified under R9-21-301 in need of special assistance;
4. Rights violations and conditions requiring investigation under Article 4 of this Chapter; and
5. Any other issue affecting the human rights of clients.

G. The agency director shall provide notice to the appropriate human rights office whenever a client is determined to need special assistance pursuant to R9-21-301.
1. The appropriate human rights advocate shall maintain a current list of all such clients.
2. The human rights committee shall make special efforts to monitor the program's compliance with Department rules for all such clients. Such efforts shall include regular visits to the residential environment where such clients live, meetings with clients to determine their satisfaction with the program, and inspection of relevant records or other documents, except as prohibited by A.R.S. §§ 36-445 et seq., 36-107, 36-504, 36-507, 36-509, and 36-517.01, and the client's right to privacy. Committee members shall obtain written consent from the client prior to inspecting client records and shall sign a written statement agreeing to adhere to all applicable laws regarding the confidentiality of such records.

H. A committee may request the services of a consultant or staff person to advise the committee on specific issues. The cost of the consultant or staff person shall be assumed by the Department or regional authority subject to the availability of funds specifically allocated for that purpose. A consultant or staff person may, in the sole discretion of the committee, be a member of another committee or an employee of the Department, regional authority, or service provider. No committee consultant or staff person shall vote or otherwise direct the committee's decisions.

I. Committee members and committee consultants and staff persons shall have access to client records to the extent necessary to discharge their respective duties, provided they sign a written statement agreeing to adhere to all applicable laws regarding the confidentiality of such records. Nothing in this rule shall be construed to require the disclosure of records or information to the extent that such information is protected by A.R.S. § 36-445 et seq.

J. On the first day of the months of January, April, July, and October of each year, each committee shall issue a quarterly report summarizing its activities for the prior quarter and make any recommendations for changes it believes the Department or regional authorities should implement. In addition, the committee may, as it deems appropriate, issue reports on specific problems or violations of client's rights. The report of a regional committee shall be delivered to the regional authority and the Division. A report of the state committee shall be delivered to the Division and the director.

K. The Department shall provide training and support to the statewide and regional human rights committee through its office of human rights.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-21-107. State Protection and Advocacy System

Staff of mental health agencies shall cooperate with the State Protection and Advocacy System in its investigations and advocacy for clients and shall provide the System access to clients, records and facilities to the extent permitted and required by federal law, 42 U.S.C.A. 10801-51. Nothing in this rule shall be construed to create an independent cause of action that does not already exist for the State Protection and Advocacy System either in state court or any administrative proceeding provided by these rules.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

ARTICLE 2. RIGHTS OF PERSONS WITH SERIOUS MENTAL ILLNESS

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-201. Civil and Other Legal Rights

A. Clients shall have all rights accorded by applicable law, including but not limited to those prescribed in A.R.S. §§ 36-504 through 36-514 and in A.A.C. Title 9, Chapter 10, Articles 10 and 50. Any individual or agency providing mental health services as defined in R9-21-101 shall not abridge these rights, including the following:
1. Those civil rights set forth in A.R.S. § 36-506;
2. The right to acquire and dispose of property, to execute instruments, to enter into contractual relationships, to hold professional or occupational or vehicle operator's licenses, unless the Client has been adjudicated incompetent or there has been a judicial order or finding that such client is unable to exercise the specific right or category of rights. In the case of a client adjudicated incompetent, these rights may be exercised by the client's guardian, in accordance with applicable law;
3. The right to be free from unlawful discrimination by the Department or by any mental health agency on the basis of race, creed, religion, sex, sexual preference, age, physical or mental handicap or degree of handicap; provided, however, classifications based on age, sex, category or degree of handicap shall not be considered discriminatory, if based on written criteria of client selection developed by a mental health agency and approved by the Department as necessary to the safe operation of the mental health agency and in the best interests of the clients involved;
4. The right to equal access to all existing generic services provided by or through the state of Arizona;

5. The right to religious freedom and practice, without compulsion and according to the preference of the client;
6. The right to vote, unless under guardianship, including reasonable assistance when desired in registering and voting in a nonpartisan and noncoercive manner;
7. The right to communicate including:
   a. The right to have reasonable access to a telephone and reasonable opportunities to make and receive confidential calls and to have assistance when desired and necessary to implement this right;
   b. The unrestricted right to send and receive uncensored and unopened mail, to be provided with stationery and postage in reasonable amounts, and to assistance when desired and necessary to implement this right;
8. The right to be visited and visit with others, provided that reasonable restrictions may be placed on the time and place of the visit but only to protect the privacy of other clients or to avoid serious disruptions in the normal functioning of the mental health agency;
9. The right to associate with anyone of the client's choosing, to form associations, and to discuss as a group, with those responsible for the program, matters of general interest to the client, provided that these do not result in serious disruptions in the normal functioning of the mental health agency. Clients shall receive cooperation from the mental health agency if they desire to publicize and hold meetings and clients shall be entitled to invite visitors to attend and participate in such meetings, provided that they do not result in serious disruptions in the normal functioning of the mental health agency;
10. The right to privacy, including the right not to be fingerprinted and photographed without consent, except as provided by A.R.S. § 36-507(2);
11. The right to be informed, in appropriate language and terms, of client rights;
12. The right to assert grievances with respect to infringement of these rights, including the right to have such grievances considered in a fair, timely, and impartial procedure, as set forth in Article 4 of these rules, and the right not to be retaliated against for filing a grievance.;
13. The right of access to a human rights advocate in order to understand, exercise, and protect a client's rights;
14. The right to be assisted by an attorney or designated representative of the client's own choice, including the right to meet in a private area at the program or facility with an attorney or designated representative. Nothing in this Section shall be construed to require the Department or any mental health agency to pay for the services of an attorney who consults with or represents a client;
15. The right to exercise all other rights, entitlements, privileges, immunities provided by law, and specifically those rights of consumers of mental health services set forth in A.R.S. §§ 36-504 through 514;
16. The same civil rights as all other citizens of Arizona, including the right to marry and to obtain a divorce, to have a family, and to live in the community of their choice without constraints upon their independence, except those constraints to which all citizens are subject.

B. Nothing in this Article shall be interpreted to:
1. Give the power, right, or authority to any person or mental health agency to authorize sterilization, abortion, or psychosurgery with respect to any client, except as may otherwise be provided by law; or
2. Restrict the right of physicians, nurses, and emergency medical technicians to render emergency care or treatment in accordance with A.R.S. § 36-512; or
3. Construe this rule to confer constitutional or statutory rights not already present.

Editor's Note: A.A.C. Title 9, Chapter 10, Article 50, as referenced in R9-21-201(A) above, does not exist in the Arizona Administrative Code as published by the Office of the Secretary of State.

Historical Note

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R9-21-202. Right to Support and Treatment

A. Clients shall have the following rights with respect to their support and treatment:
1. The right to mental health services under conditions that support the client's personal liberty and restrict such liberty only as provided by law or in these rules;
2. The right to ongoing participation in the planning of services as well as participation in the development and periodic revision of the individual service plan;
3. The right to be provided with a reasonable explanation of all aspects of one's condition and treatment;
4. The right to give informed consent to all mental health services and the right to refuse mental health services in accordance with A.R.S. §§ 36-512 and 36-513, except as provided for in A.R.S. §§ 36-520 through 36-544 and 13-3994;
5. The right not to participate in experimental treatment without informed, voluntary, written consent; the right to appropriate protection associated with such participation; and the right and opportunity to revoke such consent;
6. The right to a humane treatment environment that affords protection from harm, appropriate privacy, and freedom from verbal or physical abuse;
7. The right to enjoy basic goods and services without threat of denial or delay. For residential service providers, these basic goods and services include at least the following:
   a. A nutritionally sound diet of wholesome and tasteful food available at appropriate times and in as normal a manner as possible;
   b. Arrangements for or provision of an adequate allowance of neat, clean, appropriate, and seasonable clothing that is individually chosen and owned;
   c. Assistance in securing prompt and adequate medical care, including family planning services, through community medical facilities;
   d. Opportunities for social contact in the client's home, work or schooling environments;

e. Opportunities for daily activities, recreation and physical exercise;
f. The opportunity to keep and use personal possessions; and
g. Access to individual storage space for personal possessions;

8. The right to be informed, in advance, of charges for services;
9. The right to a continuum of care in a unified and cohesive system of community services that is well integrated, facilitates the movement of clients among programs, and ensures continuity of care;
10. The right to a continuum of care that consists of, but is not limited to, clinical case management, outreach, housing and residential services, crisis intervention and resolution services, mobile crisis teams, vocational training and opportunities, day treatment, rehabilitation services, peer support, social support, recreation services, advocacy, family support services, outpatient counseling and treatment, transportation, and medication evaluation and maintenance;
11. The right to a continuum of care with programs that offer different levels of intensity of services in order to meet the individual needs of each client;
12. The right to appropriate mental health treatment, based on each client's individual and unique needs, and to those community services from which the client would reasonably benefit;
13. The right to community services provided in the most normal and least restrictive setting, according to the least restrictive means appropriate to the client's needs;
14. The right to clinical case management services and a case manager. The clinical team negotiates and oversees the provision of services and ensures the client's smooth transition with service providers and among agencies;
15. The right to participate in treatment decisions and in the development and implementation of the client's ISP, and the right to participate in choosing the type and location of services, consistent with the ISP;
16. The right to prompt consideration of discharge from an inpatient facility and the identification of the steps necessary to secure a client's discharge as part of an ISP;
17. The rights prescribed in Articles 3 and 4 of this Chapter, including the right to:
    a. A written individual service plan;
    b. Assert grievances; and
    c. Be represented by a qualified advocate or other designated representative in the development of the ISP and the inpatient and discharge plan and in the grievance process, in order to understand, exercise and protect the client's rights.

B. Subsection (A) shall not be construed to confer constitutional or statutory rights not already present.

Historical Note

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R9-21-203. Protection from Abuse, Neglect, Exploitation, and Mistreatment

A. No mental health agency shall mistreat a client or permit the mistreatment of a client by staff subject to its direction. Mistreatment includes any intentional, reckless or negligent action or omission which exposes a client to a serious risk of physical or emotional harm. Mistreatment includes but is not limited to:
1. Abuse, neglect or exploitation;
2. Corporal punishment;
3. Any other unreasonable use or degree of force or threat of force not necessary to protect the client or another person from bodily harm;
4. Infliction of mental or verbal abuse, such as screaming, ridicule, or name calling;
5. Incitement or encouragement of clients or others to mistreat a client;
6. Transfer or the threat of transfer of a client for punitive reasons;
7. The use of any restraint or seclusion as a punishment or primarily for the convenience of staff;
8. Any act in retaliation against a client for reporting any violation of the provisions of this Chapter to the Department; or
9. Commercial exploitation.

B. The following special sanctions shall be available to the Department, in addition to those set forth in A.A.C. Title 9, Chapter 10, Article 10 of its rules, to protect the interests of the client involved as well as other current and former clients of the mental health agency.
1. Mistreatment of a client by staff or persons subject to the direction of a mental health agency may be grounds for suspension or revocation of the license of the mental health agency or the provision of Departmental financial assistance, and, with respect to employees of the Department, grounds for disciplinary action, which may include dismissal.
2. Failure of an employee of the Department to report to the Department any instance of mistreatment within any mental health agency subject to this Chapter shall be grounds for disciplinary action, which may include dismissal.
3. Failure of an agency director to report client deaths and allegations of sexual and physical abuse to the Department and to comply with the procedures described in Article 4 of this Chapter for the processing and investigation of grievances and reports shall be grounds for suspension of the license of the mental health agency or the provision of Departmental financial assistance, and, with respect to a service provider directly operated by the Department, grounds for disciplinary action, which may include dismissal.
4. The agency director shall report all allegations of mistreatment and denial of rights to the Office of Human Rights and the regional authority for review and monitoring in accordance with R9-21-105.

C. An agency director shall report all incidents of abuse, neglect, or exploitation to the appropriate authorities as required by A.R.S. § 46-454 and shall document all such reports in the mental health agency's records.

D. Where an agency director has reasonable cause to believe that a felony relevant to the functioning of the program has been committed by staff persons subject to the agency's direction, a report shall be filed with the county attorney.

E. The identity of persons making reports of abuse, neglect, exploitation or mistreatment shall not be disclosed by the agency director or by the Department, except as necessary to investigate the subject matter of the report.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-21-204. Restraint and Seclusion

A. Restraint or seclusion shall only be used where a client poses a likelihood of serious physical harm as defined in R9-21-101.

B. Restraint or seclusion shall not be used for the convenience of staff, as a method of punishment, in lieu of adequate staffing, or as a substitute for appropriate treatment.

C. Staff qualifications and staffing ratio requirements shall be adequate to safely provide restraint or seclusion as required by this rule without jeopardizing staffing of the primary program.

D. Each mental health agency shall develop and implement written policies and training programs for the use and prevention of seclusion and restraint by employees of the provider and alternatives thereto. The policies and training shall also include procedures for the immediate release of clients in seclusion or restraint during emergencies. The policies and training program shall be consistent with this rule and shall be filed with and approved by the Division. The mental health agency shall provide training on this rule, the agency's policies, and the appropriate techniques for placing a client in all types of seclusion and restraint used at the agency.

E. No form of restraint or seclusion shall be used with a client except:

1. When in full compliance with the policies of the mental health agency governing the use of restraint and seclusion;
2. After all less restrictive and reasonably available methods of control have been attempted and were unsuccessful; and
3. In such a manner as to afford the client the greatest possible comfort and to avoid physical injury and minimize mental distress to the greatest extent possible.

F. Seclusion and restraint shall not be used by any community service provider and shall only be used by an inpatient facility or by a mental health agency licensed to provide crisis services, but only to the extent that such seclusion or restraint is expressly permitted by and in compliance with these rules and other applicable licensing rules and statutes for that inpatient facility or provider of crisis services.

G. Seclusion or restraint shall only be used when authorized by a written order from a licensed physician who has personally examined the client before authorizing the restraint or seclusion. The physician's written order shall document the date and time of the order, the date and time of personal examination, and the type of restraint authorized.

1. If a physician is not available at the time of the emergency, a licensed registered nurse may initiate the mechanical restraint or seclusion provided that:
   a. Immediately thereafter, and
      i. No later than 15 minutes thereafter, the nurse initiates a call to obtain a telephone order from a licensed physician; and
      ii. No later than 30 minutes thereafter, the nurse obtains a telephone order from a licensed physician.
   b. The physician, in consultation with the nurse, shall determine whether it is clinically necessary for the physician to personally examine the client at that time. The determination shall be based upon the client's current and past medical, physical and psychiatric condition. The determination and the reasons therefor shall be documented in the client's record.
2. If a physician is not available at the time of the emergency, a licensed registered nurse may initiate pharmacological restraint by obtaining a telephone order from a physician.
   a. The physician, in consultation with the nurse, shall determine whether it is clinically necessary for the physician to personally examine the client at that time. The determination shall be based upon the client's current and past medical, physical and psychiatric condition. The determination and the reasons therefor shall be documented in the client's record.
   b. An order for pharmacological restraint shall be limited to the dosage necessary to achieve its effect. An order for pharmacological restraint shall not include the administration of time-released drugs which are designed to be effective for more than an eight-hour period.
   c Any subsequent orders for pharmacological restraint shall be issued in accordance with paragraph (G)(2)(a) and (b) above, except that only one subsequent order may be made without personal examination of the client by the physician.

H. PRN orders shall not be used for any form of restraint or seclusion.

I. The use of any form of restraint or seclusion shall be recorded in the client's record with the following information:

1. The nature of the restraint or seclusion used;
2. The reason for the restraint or seclusion, including the facts and behaviors justifying it;
3. The types of less restrictive alternatives which were attempted and the reasons for their failure;
4. The names of the persons authorizing and employing the restraint or seclusion;
5. The physician's evaluation and assessment of the need for seclusion or restraint and the date and times thereof;
6. The physician's determination and the reasons therefor as to whether personal examination of a client is necessary pursuant to subsection (G) above;
7. The specific and measurable criteria for client release from mechanical restraint or seclusion with documentation to support that the client was notified of the release criteria and the client's response;
8. The date and time of day the restraint or seclusion was authorized and administered;
9. The date and times all periodic checks were made and by whom; and
10. The duration of the restraint or seclusion.

J. If, at any time during the ordered period of seclusion or mechanical restraint, a licensed physician or licensed registered nurse determines that the emergency which justified the restraint has subsided, or if the required documentation reflects that the criteria for release have been met, the client shall be released and the order terminated. At the end of the ordered period of seclusion or restraint, the client shall be released unless a new order is written by a physician in accordance with subsections (G) and (M), which documents that the emergency condition continues.

K. For any client in mechanical restraint, the physician shall determine whether one-to-one supervision is clinically appropriate and shall document the determination and the reasons therefor in the client's record.

L. Any client under restraint or seclusion shall be monitored as follows:

1. The client shall be personally examined at least every 15 minutes for the purpose of ensuring the client's general comfort and safety and determining the client's need for food, fluid, bathing, and access to the toilet. Personal examinations shall be conducted by staff members with documented training in the appropriate use of restraint and seclusion and who are working under the supervision of a licensed physician or a licensed registered nurse.
2. A licensed registered nurse shall personally examine the client every hour to assess the status of the client's mental and physical condition and to ensure the client's continued well-being.
3. If the client has any medical condition that may be adversely affected by the restraint or seclusion, the client shall be monitored every five minutes.
4. If other clients have access to a client being restrained or secluded, the client being restrained or secluded shall be continuously supervised by a staff member on a one-to-one basis.
5. At least every two hours, the client shall be released from mechanical restraint or seclusion for at least ten minutes, unless a licensed physician or licensed registered nurse determines that such release is clearly contraindicated and documents the determination in the client's record.
6. Nutritious meals shall not be withheld from a client who is restrained, if mealtimes fall during the period of restraint. Staff shall supervise all meals provided to the client while in restraint or seclusion.
7. The results of the monitoring under this subsection shall be recorded in the client's record.

M. An order for mechanical restraint or seclusion shall be effective for a maximum of three hours. If, at any time during the three hour period, a licensed registered nurse determines that the emergency which justified the restraint has subsided, the client shall be released and the order terminated. At the end of the three-hour period, the client must be released unless a renewal or new order for mechanical restraint or seclusion is written by a licensed physician. All renewal or new orders for mechanical restraint or seclusion shall be issued in accordance with subsection (G) above, except that only one renewal or new order may be made without personal examination of the client by the physician.

N. No order for mechanical restraint or seclusion shall be renewed for more than 12 consecutive hours without the review and approval by the medical director or designee of the mental health agency in consultation with the client and relevant staff to discuss and evaluate the needs of the client. The review and approval, if any, and the reasons justifying any continued restraint or seclusion shall be documented in the client's record.

O. If a client requires the repeated or continuous use of restraint or seclusion during a 24-hour period, a review process shall be initiated immediately and shall include the client and all relevant staff persons and clinical consultants who are available to evaluate the need for an alternative treatment setting and the needs of the client. The review and its findings and recommendations shall be documented in the client's record.

P. Whenever a client is subjected to extended or repeated orders for restraint or seclusion during a 30-day period, the medical director shall require a special meeting of the client's clinical team pursuant to R9-21-314 to determine whether other treatment interventions would be useful and whether modifications of the ISP or IDTP are required.

Q. As part of a mental health agency's quality assurance program, an audit will be conducted and a report filed with the agency's medical director within 24 hours, or the first working day, for every episode of the use of restraint or seclusion to ensure that the agency's use of seclusion or restraint is in full compliance with the rules set forth in this Article.

R. Not later than the tenth day of every month, the program director shall prepare and file with the Division and the Office of Human Rights a written report describing the use of any form of restraint or seclusion during the preceding month in the mental health agency or by any employees of the agency. In the case of an inpatient facility, the report shall also be filed with any patient or human rights committee for that facility.

S. The Department's human rights committee, the Office of Human Rights, and any applicable regional human rights committee shall review such reports to determine if there has been any inappropriate or unlawful use of restraint or seclusion and to determine if restraint or seclusion may be used in a more effective or appropriate fashion.

T. If any human rights committee or the Office of Human Rights determines that restraint or seclusion has been used in violation of any applicable law or rule, the committee or Office may take whatever action is appropriate, including investigating the matter itself or referring the matter to the Division for remedial action.

Historical Note

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R9-21-205. Labor

A. No client shall be required to perform labor which involves the essential operation and maintenance of the service provider or the regular care, treatment or supervision of other clients, provided however, that:

1. Only a residential service provider may require clients to perform activities related to maintaining their bedrooms, other personal areas, and their clothing and personal possessions in a neat and clean manner.

2. Clients may perform labor in accordance with a planned and supervised program of vocational and rehabilitation training as set forth in an ISP or IDTP developed pursuant to Article 3 of this Chapter.

B. Any client may voluntarily perform any labor available.

C. The requirements of federal and state laws relating to wages, hours of work, workers' compensation and other labor standards shall be met with respect to all labor.

Historical Note

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R9-21-206. Competency and Consent

A. No clients shall be deemed to be incompetent to manage their affairs, to contract, to hold professional, occupational or vehicle operator's licenses, to make wills, to vote or to exercise any other civil or legal right solely by reason of admission to a mental health agency.

B. All clients shall be presumed to be legally competent to conduct their personal and financial affairs, unless otherwise determined by a court in a guardianship or conservatorship proceeding.

C. In any eligibility determination, assessment or periodic review of a client's ability to make informed decisions, rendered pursuant to Article 3 of these rules, the appropriateness of establishing or removing a guardianship, temporary guardianship, conservatorship, or guardianship *ad litem* shall be determined as follows:

1. A client shall be determined to be in need of guardianship or conservatorship only if the client's ability to make important decisions concerning the client or the client's property is so limited that the absence of a person with legal authority to make such decisions for the client creates a serious risk to the client's health, welfare or safety.
2. Although the capability of the client to make important decisions is the central factor in determining the need for guardianship, the capabilities of the client's family, the client's living circumstances, the probability that available treatment will improve the client's ability to make decisions on one's own behalf, and the availability and utility of nonjudicial alternatives to guardianships such as trusts, representative payees, citizen advocacy programs, or community support services should also be considered.
3. The assessment or periodic review should identify the specific area(s) of the client's functioning which forms the basis of the recommendation for the appointment or removal of a guardian or conservator, such as an inability to respond appropriately to health problems or consent to medical care, or an inability to manage savings or routine expenses.
4. If the client has been determined to be incapable of making important decisions with regard to his personal or financial affairs, and if nonjudicial, less restrictive alternatives such as trusts, representative payees, cosignatory bank accounts, and citizen advocates are inadequate to protect the client from a substantial and unreasonable risk to the client's health, safety, welfare, or property, the client's nearest living relatives shall be notified with an accompanying recommendation that a guardian or conservator be appointed.
5. If the client is capable of making important decisions concerning his health, welfare, and property, either independently or through other less restrictive alternatives such as trusts, representative payees, cosignatory bank accounts, and citizen advocates, the client's nearest living relative shall be notified with an accompanying recommendation that any existing guardian or conservator be removed.
6. If the client has been determined to require or no longer require assistance in the management of financial or personal affairs, and the nearest living relative cannot be found or is incapable of or not interested in caring for the client's interest, the mental health agency shall assist in the recruitment or removal of a trustee, representative payee, advocate, conservator, or guardian. Nothing in this Section shall be construed to require the Department or any regional authority or service provider to pay for the recruitment, appointment or removal of a trustee, representative payee, advocate, conservator, or guardian.
7. Mental health agencies shall devise procedures to ensure that suspected improprieties of a guardian, conservator, trustee, representative payee, or other fiduciary are reported to the court or other appropriate authorities.

D. The informed consent of the client or guardian shall be required in at least the following circumstances:

1. Prior to medical treatment, including mental health treatment, except in the case of a true medical emergency as provided in A.R.S. § 36-512 or an emergency as provided in A.R.S. § 36-513 and R9-21-204;
2. Prior to involvement of the client in research activities approved under Department rules or policy;
3. Prior to the client's admission to any program operated by a mental health agency, except pursuant to a court order as provided in A.R.S. Title 36, Chapter 5, Articles 4 and 5;
4. Prior to the release of personal information to other mental health agencies or individuals, except as otherwise permitted by A.R.S. § 36-504, 36-509, or 36-517.01 or R9-21-209.

E. The authorization for medical treatment shall be given by:

1. The client if capable of making medical decisions and if not a minor or under guardianship;
2. The client's guardian, if any; or
3. A court of competent jurisdiction.

F. Consent to medical treatment shall be given voluntarily and only after the following information is provided to the client or guardian:

1. The intended outcome, nature and procedures involved in the proposed treatment;
2. The risks, including side effects if any, of the proposed treatment as well as the risks of not proceeding;
3. The alternatives to the proposed treatment, particularly alternatives offering less risk or other adverse effects; and
4. That consent may be withheld or withdrawn at any Lime, with no punitive action taken against the client.

G. A consent form, which indicates that the information described in subsection (F) above was provided, shall be signed by the client or the guardian.

1. Consent may be revoked at any time by the client or guardian through a reasonably clear statement in writing.
2. A client shall receive assistance in writing the revocation if necessary.
3. If consent is revoked, treatment shall be promptly discontinued, provided that a course of treatment may be phased out where necessary to avoid the harmful effects of abrupt discontinuance.

Historical Note

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R9-21-207. Medication

A. Medication shall only be administered with the informed consent of the client or Title 36 guardian. Information relating to common risks and side effects of the medication, the procedures to be taken to minimize such risks, and a description of any clinical indications that might require suspension or termination of the drug therapy shall be available to the client, guardian, if any, and the staff in every mental health agency. Such information shall be available to family members in accordance with A.R.S. §§ 36-504, 36-509, and 36-517.01.

B. All clients have a right to be free from unnecessary or excessive medication.

C. Medication shall not be used as punishment, for the convenience of the staff, or as a substitute for other mental health services and shall be given in the least amount medically necessary with particular emphasis placed on minimizing side effects which otherwise would interfere with aspects of treatment.

D. Medication administered by a mental health agency shall be prescribed by a licensed physician, certified physician assistant, or a licensed nurse practitioner.
1. Psychotropic medication shall be prescribed by:
   a. A psychiatrist who is a licensed physician; or
   b. A licensed nurse practitioner, certified physician assistant, or physician trained or experienced in the use of psychotropic medication, who has seen the client and is familiar with the client's medical history or, in an emergency, is at least familiar with the client's medical history.
2. Each client receiving psychotropic medication shall be seen monthly or as indicated in the client's ISP by a licensed nurse practitioner, certified physician's assistant or physician prescribing the medication, who shall note in the client's record:
   a. The appropriateness of the current dosage,
   b. All medication being taken by the client and the appropriateness of the mixture of medications,
   c. Any signs of tardive dyskinesia or other side effects,
   d. The reason for the use of the medication, and
   e. The effectiveness of the medication.
3. When a client on psychotropic medication receives a yearly physical examination, the results of the examination shall be reviewed by the physician prescribing the medication. The physician shall note any adverse effects of the continued use of the prescribed psychotropic medication in the client's record.
4. Whenever a prescription for medication is written or changed, a notation of the medication, dosage, frequency of administration, and the reason why the medication was ordered or changed shall be entered in the client's record.

E. Self-administration of medication by clients shall be permitted unless otherwise restricted by the responsible physician or licensed nurse practitioner. Such clients shall be trained in self-administration of medication and, if necessary, shall be monitored by trained staff.

F. Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation and security.

G. PRN orders for medication shall not be used as pharmacological restraint.

Historical Note

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R9-21-208. Property and Possessions

A. No mental health agency shall interfere with a client's right to acquire, retain and dispose of personal property, including the right to maintain an individual bank account, except where:
1. The client is under guardianship, conservatorship, or has a representative payee;
2. Otherwise ordered by court; or
3. A particular object, other than money or personal funds, poses an imminent threat of serious physical harm to the client or others. Any restriction on the client's control of property deemed to pose an imminent threat of serious physical harm shall be recorded in the client's record together with the reasons therefor.

B. If a mental health agency, which offers assistance to its clients in managing their funds, takes possession or control of a client's funds at the request of the client, guardian, or by court order, the mental health agency shall issue a receipt to the client or guardian for each transaction involving such funds. If deposited funds in excess of $250 are held by the mental health agency, where the likelihood of the client's stay will exceed 30 days, an individual bank account or an amalgamated client trust account shall be maintained for the benefit of the client. All interest shall become the property of the client or the fair allocation thereof in the case of an amalgamated client trust account. The mental health agency shall provide a bond to cover client funds held.
1. Unless a guardian, conservator, or representative payee has been appointed, the client shall have an unrestricted right to manage and spend deposited funds.

2. The mental health agency shall obtain prior written authorization from the client, the guardian or conservator for any arrangement involving shared or delegated management responsibilities. The authorization shall set forth the terms and conditions of the arrangement.
3. Where the mental health agency has shared or delegated management responsibilities, the mental health agency shall meet the following requirements:
   a. Client funds shall not be applied to goods or services which the mental health agency is obligated by law or funded by contract to provide, except as permitted by the client fee schedule authorized by the Department;
   b. The mental health agency and its staff shall have no direct or indirect ownership or survivorship interest in the funds;
   c. Such arrangements shall be accompanied by a training program, documented in the ISP, to eliminate the need for such assistance;
   d. Staff shall not participate in arrangements for shared or delegated management of the client's funds except as representatives of the mental health agency;
   e. Any arrangements made to transfer a client from one mental health agency to another shall include provisions for transferring shared or delegated management responsibilities to the receiving mental health agency;
   f. The client shall be informed of all proposed expenditures and any expression of preference within reason shall be honored; and
   g. Expenditures shall be made only for purposes which directly benefit the client in accordance with the client's interests and desires.
4. A record shall be kept of every transaction involving deposited funds, including the date and amount received or disbursed, and the name of the person to or from whom the funds are received or disbursed. The client, guardian, conservator, mental health agency or regional human rights advocate or other representative may demand an accounting at any reasonable time, including at the time of the client's transfer, discharge or death.
5. Any funds so deposited shall be treated for the purpose of collecting charges for care the same as any other property held by or on behalf of the client. The client or guardian shall be informed of any possible charges before the onset of services.

Historical Note

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R9-21-209. Records

A. Records of a client who is currently receiving or has received services from a mental health agency shall be private and not open to inspection except to those individuals authorized pursuant to A.R.S. § 36-504, 36-507, 36-509, or 36-517.01.

B. Inspection by the client, the client's guardian, attorney, paralegal working under the supervision of an attorney, or any other designated representative shall be permitted as follows:
1. The client shall be permitted to inspect and copy the client's record upon request, except as prohibited by A.R.S. § 36-507. If an attending physician determines that client inspection is contraindicated under A.R.S. § 36-507, the determination, the reasons therefor, and those portions of the record that are contraindicated shall be noted in the client record. Only those portions of the record that are contraindicated may be withheld from the client. If any portion of the client record is withheld as contraindicated, the physician shall inform the client of the right to grieve under Article 4 of this Chapter.
2. The client's guardian shall be permitted to inspect and copy the client's record upon request, except as prohibited by A.R.S. § 36-504, 36-507, 36-509 or 36-517.01.
3. An attorney, paralegal working under the supervision of an attorney, or other designated representative of the client shall be permitted to inspect and copy the record, if such attorney or representative furnishes written authorization from the client or guardian.
4. When necessary for the understanding of the client, guardian, attorney, paralegal working under the supervision of an attorney, or designated representative, staff of the mental health agency possessing the records shall read or interpret the record. Upon request, clients shall also be permitted to examine a copy of their record in accordance with paragraph (B)(1). The mental health agency may require the client to examine the record in the presence of a staff person when necessary to ensure the integrity of the record.

C. Inspection by specially authorized persons or entities shall be permitted as follows:
1. Those individuals and agencies listed in A.R.S. § 36-509.
2. Records of a client shall be open to inspection upon proper judicial order, whether or not such order is made in connection with pending judicial proceedings.
3. Records of a client shall be made available to a physician who requests such records in the treatment of a medical emergency, provided that the client is given notice of such access as soon as possible but no later than 12 hours from the request.
4. Records of a client shall be made available to Division staff authorized by the Department to monitor the quality of services being provided by the mental health agency to the client.
5. Records of a client shall be made available to guardians and family members actively participating in the client's care, treatment or supervision as provided by A.R.S. §§ 36-504, 36-509 and 36-517.01. Except when inspection of a client's record is required under a proper judicial order or by a physician in a medical emergency, a client, guardian or family member may challenge the decision to allow or deny inspection of the record by filing a request for administrative and judicial review in accordance with the provisions of A.R.S. § 36-517.01. Once a request is filed, no further disclosure of records shall be made until the review has been completed.

D. Records shall be open to inspection by other third parties only upon the written consent of the client or guardian. Before consent is given, the client or guardian shall be offered an opportunity to examine the information to be disclosed and be

provided with the name of the recipient and uses to be made of the information.

E. The fee for copying records obtained under this rule shall be no more than the actual expense of reproducing the record or the requested parts thereof.

F. A client or guardian shall be informed of a court order or subpoena commanding production of a client's record as soon as possible and in any event prior to the date for production and of the client's or guardian's right to request the court to quash or modify the order or subpoena.

G. The records maintained by the mental health agency shall contain accurate, complete, timely, pertinent and relevant information.

1. If a client or guardian believes that the record contains inaccurate or misleading information, the client or guardian may prepare, with assistance if requested, a statement of disagreement which shall be entered in the record.
2. If a client or guardian objects to the collection of the information in the record, the client or guardian may file a grievance pursuant to Article 4 of this Chapter.

H. A list shall be kept of every person or organization who inspects the client's records, other than the client's clinical team, the uses to be made of that information, and the person authorizing access. A list of such access shall be placed in the client's record and shall be made available to the client or other designated representative.

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R9-21-210. Policies and Procedures of Service Providers

A. A mental health agency may establish reasonable policies and procedures for the provision of mental health services which are consistent with Articles 1 through 5 of these rules and with all other requirements of Arizona law. No policy or procedure may restrict any right protected by these rules.

B. The mental health agency shall inform all prospective clients of its policies and procedures prior to their consenting to admission to the program pursuant to R9-21-206(D)(3).

C. If a client acts in a manner that is seriously in disregard of a reasonable policy, the agency director shall make all reasonable efforts to respond to the situation, including making reasonable accommodation to the program's policy if the client's failure to conform to a reasonable policy is due to the client's disability.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-211. Notice of Rights

A. Every mental health agency shall provide written notice of the civil and legal rights of its clients by posting a copy of ADHS Form MH-211, "Notice of Client's Rights", set forth in Exhibit A, in one or more areas of the agency so that it is readily visible to clients and visitors.

B. In addition to posting as required by subsection (A), a copy of ADHS Form MH-211, set forth in Exhibit B, shall be given to each client, or guardian if any, at the time of admission to the agency for evaluation or treatment. The person receiving the notice shall be required to acknowledge in writing receipt of the notice and the acknowledgment shall be retained in the client's record.

C. Every mental health agency shall provide written notice of the terms of A.R.S. SS36-506 to each client upon discharge by giving the client a copy of ADHS Form MH-209, "Discrimination Prohibited".

D. All notices required by this rule shall be provided and posted in both English and Spanish.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

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EXHIBIT A
NOTICE OF LEGAL RIGHTS FOR PERSONS WITH SERIOUS MENTAL ILLNESS

If you have a serious or chronic mental illness, you have legal rights under federal and state law. Some of these rights include:

- The right to appropriate mental health services based on your individual needs;
- The right to participate in all phases of your mental health treatment, including individual service plan (ISP) meetings;
- The right to a discharge plan upon discharge from a hospital;
- The right to consent to or refuse treatment (except in an emergency or by court order);
- The right to treatment in the least restrictive setting;
- The right to freedom from unnecessary seclusion or restraint;
- The right not to be physically, sexually, or verbally abused;
- The right to privacy (mail, visits, telephone conversations);

- The right to file an appeal or grievance when you disagree with the services you receive or your rights are violated;
- The right to choose a designated representative(s) to assist you in ISP meetings and in filing grievances;
- The right to a case manager to work with you in obtaining the services you need;
- The right to a written ISP that sets forth the services you will receive;
- The right to associate with others;
- The right to confidentiality of your psychiatric records;
- The right to obtain copies of your own psychiatric records (unless it would not be in your best interests to have them);
- The right to appeal a court-ordered involuntary commitment and to consult with an attorney and to request judicial review of court-ordered commitment every 60 days;
- The right not to be discriminated against in employment or housing.

If you would like information about your rights, you may request a copy of the "Your Rights in Arizona as an Individual with Serious Mental Illness" brochure or you may also call the Arizona Department of Health Services, Office of Human Rights at 1-800-421-2124.

ADHS/BHS Form MH-211 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 21, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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EXHIBIT B
NOTICE

Discrimination Prohibited

Pursuant to A.R.S. § 36-506 and R9-21-101(B)

A. Persons undergoing evaluation or treatment pursuant to this Chapter shall not be denied any civil right, including, but not limited to, the right to dispose of property, sue and be sued, enter into contractual relationships and vote. Court-ordered treatment or evaluation pursuant to this Chapter is not a determination of legal incompetency, except to the extent provided in A.R.S. § 36-512.

B. A person who is or has been evaluated or treated in an agency for a mental disorder shall not be discriminated against in any manner, including but not limited to:
   1. Seeking employment.
   2. Resuming or continuing professional practice or previous occupation.
   3. Obtaining or retaining housing.
   4. Obtaining or retaining licenses or permits, including but not limited to, motor vehicle licenses, motor vehicle operator's and chauffeur's licenses and professional or occupational licenses.

C. "Discrimination" for purposes of this Section means any denial of civil rights on the grounds of hospitalization or outpatient care and treatment unrelated to a person's present capacity to meet the standards applicable to all persons. Applications for positions, licenses and housing shall contain no requests for information which encourage such discrimination.

D. Upon discharge from any treatment or evaluation agency, the patient shall be given written notice of the provisions of this Section.

EXHIBIT B (Page 2)
AVISO

Discriminacion Prohibida

Conforme a A.R.S. § 36-506 y R9-21-101(B)

A. A las personas que estan bajo evaluacion o tratamiento conforme a este capitulo, no se les negara ningun derecho civil, incluyendo pero no limitado a, el derecho a disponer de propiedad, a demandar y ser demandado, a tomar parte en relaciones contractuales y a votar. El tratamiento o evaluacion ordenado por la corte conforme a este capitulo no es una determinacion de incompetencia legal, excepto hasta el punto proveido en la seccion 36-512.

B. No se haran discriminaciones de ninguna clase, en contra de una persona que ha sido o esta siendo evaluada o tratada en una agencia debido a un desorden mental, incluyendo pero no limitado a:
   1. Buscar trabajo.
   2. Reasumir o continuar una practica profesional u ocupacion previa.
   3. Obtener o retener vivienda.
   4. Obtener o retener licencias o permisos, incluyendo pero no limitado a, licencias para vehiculo de motor, licencias de operador de vehiculo de motor y de chofer, y licencias ocupacionales o profesionales.

C. "Discriminacion" para propositos de esta seccion quiere decir cualquier denegacion de derechos civiles por motives de hospitalizacion o tratamiento externo no relacionado a la capacidad actual de la persona para cumplir con las normas aplicables a toda persona. Las solicitudes para posiciones, licencias y vivienda no contendran peticion de informacion que pueda fomentar tal discriminacion.

D. Al ser dado de alta de cualquier agencia de tratamiento o evaluacion, se dara al paciente notificacion por escrito sobre las provisiones de esta seccion.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

ARTICLE 3. INDIVIDUAL SERVICE PLANNING FOR MENTAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the

Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-301. General Provisions

A. Responsibilities of the regional authority, clinical team, and case manager.

1. The regional authority is responsible for providing, purchasing, or arranging for all services identified in individual service plans.
   a. The regional authority shall perform all intake and case management for its region. The regional authority may contract with a mental health agency to perform intake or case management but only with the written approval of the Department, which may be given in its sole discretion.
   b. Other services may be provided directly by programs operated by the Department or by the regional authority through contracts with service providers which are licensed or approved by the Department, or through arrangements with other agencies or generic providers.
2. The regional authority and the clinical team shall work diligently to ensure equal access to generic services for its clients in order to integrate the client into the mainstream of society.
3. The initial clinical team shall work to meet the individual's needs from the date of application or referral for services until such time as eligibility is established and an Individual Service Plan (ISP) is developed.
4. The assigned clinical team shall be primarily responsible for providing continuous treatment, outreach and support to a client, for identifying appropriate mental health services, and for developing, implementing and monitoring individual service plans for clients.
5. The case manager, in conjunction with the clinical team, shall:
   a. Locate services identified in the ISP;
   b. Confirm the selection of service providers and include the names of such providers in the ISP;
   c. Obtain a written client service agreement from each provider;
   d. Be responsible for ensuring that services are actually delivered in accordance with the ISP; and
   e. Monitor the delivery of services rendered to clients. Monitoring shall consider, at a minimum, the consistency of the services with the goals and objectives of the ISP.
6. The case manager shall also be responsible to:
   a. Initiate and maintain close contact with clients and service providers;
   b. Provide support and assistance to clients, with their consent and consistent with their individual needs;
   c. Ensure that all service providers participate in the development of their clients' ISPS;
   d. Ensure that each inpatient facility develops an Inpatient Treatment and Discharge Plan (ITDP) pursuant to R9-21-312 which is integrated in and consistent with the ISP;
   e. Assess progress toward, and identify impediments to, the achievement of the client's goals and objectives identified in the ISP;
   f. Promote client involvement in the development, review, and implementation of the ISP;
   g. Attempt to resolve problems and disagreements with respect to any component of the ISP;
   h. Assist in resolving emergencies concerning the implementation of the ISP;
   i. Attend all periodic reviews of the ISP and ITDP meetings;
   j. Assist in the exploration of less restrictive alternatives to hospitalization or involuntary commitment; and
   k. Otherwise coordinate services provided to the client.
7. If a case manager is assigned to a client who, at any time, is admitted to an inpatient facility, the case manager shall ensure the development, modification or revision of a client's ISP and the integration of the ITDP in accordance with this Article.
   a. The inpatient facility clinician responsible for coordinating the ITDP shall immediately notify the client's case manager of the time of the admission and ensure that all treatment and discharge planning includes the case manager.
   b. The case manager shall be provided notice of all treatment and discharge meetings, shall participate as a full member of the inpatient facility treatment team in such meetings, shall receive periodic and other reports concerning the client's treatment, and shall be responsible for identifying and securing appropriate community services to facilitate the client's discharge.
   c. If no case manager has been assigned, the inpatient facility clinician primarily responsible for the client's inpatient care shall, within three days of admission, make a referral to the appropriate regional authority for the appointment of a case manager.
   d. Delays in the assignment of a case manager or in the development or modification of an ISP or ITDP shall not be construed to prevent the clinically appropriate discharge of a client from an inpatient facility.
   e. Inpatient facilities shall establish a mechanism for the credentialing of case managers and other members of the clinical team in order that they may participate in ITDP meetings.

B. Consent to service planning.

1. It is the responsibility of the regional authority and its service providers to engage in service planning, including the provision of assessments, case management, ISPs, ITDPS, and service referrals, in accordance with the provisions of these rules for the benefit of clients requesting, receiving or referred for mental health services. Clients and their guardians may refuse to participate in or to receive any service planning. In the event of such refusal, service planning will not be provided unless:
   a. There is an emergency in which a qualified clinician determines that immediate intervention is necessary to prevent serious harm Lo the client or others; or
   b. The client is subject to court-ordered evaluation or treatment.
2. A client's refusal to accept a particular service, including case management services, or a particular mode or course of treatment, shall not be grounds for refusing a client's access to other services which the client accepts.
3. A physical examination shall not be conducted over a client's refusal unless the examination is consented to by the client's guardian, or the examination is otherwise required by court order.
4. A decision to provide services, including assessment, service planning, and case management services, to a client who is refusing such services, or a decision not to

provide such services to such an individual, may be appealed in accordance with the provisions of R9-21-315. This subsection does not limit the rights of a client to accept, reject, or appeal particular results of the service planning process as set forth in other applicable provisions of these rules.

C. Clients with special needs.
1. Whenever, pursuant to an assessment or in the development or review of any plan prepared under this Article, it is determined that a client is in need of or would benefit from special assistance, counsel or advice in making treatment decisions or in enforcing the client's rights, the case manager shall:
   a. Notify the regional authority, the Office of Human Rights, and the appropriate human rights committee of the client's need so that the client can be provided special assistance from the human rights advocate or special review by the human rights committee; and
   b. If the client does not have a guardian, identify a friend, relative or other person who is willing to serve as a designated representative of the client.
2. The clinical team shall make arrangements to have qualified interpreters or other reasonable accommodations, including qualified interpreters for the deaf, present at any assessment, meeting, service delivery, notice, review, or grievance for clients who cannot converse adequately in spoken English.
3. Clients who are incarcerated in jails shall receive ISPs in accordance with R9-21-307. If legitimate security requirements of any jail in which a client is incarcerated require a reasonable modification of a specific procedure set forth in this rule, the clinical team may modify the method for preparing the ISP only to the extent necessary to accommodate the legitimate security concerns.
   a. No modification may unreasonably restrict the client's right to participate in the ISP process;
   b. No modification may alter the standards for developing an ISP, the client's right to obtain services set forth in the ISP, as provided in this Article, or the client's right to appeal any aspect of treatment planning pursuant to R9-21-315, including the decision to modify the process for security reasons.

D. Notices to the individual.
1. Any individual or mental health agency required to give notice to an individual of any documents, including eligibility determinations, assessment reports, ISPs, and ITDPs pursuant to this rule shall do so by:
   a. Providing a copy of the document to the individual;
   b. Providing copies to any designated representative and guardian;
   c. Personally explaining to the individual and designated representative and/or guardian any right to accept, reject, or appeal the contents of the document and the procedures for doing so under this Article.
2. Individuals requesting or receiving mental health services shall be informed:
   a. of the right to request an assessment;
   b. Of the right to have a designated representative assist the client at any stage of the service planning process;
   c. Of the right to participate in the development of any plan prepared under this Article, including the right to attend all planning meetings;
   d. Of the right to appeal any portion of any assessment, plan, or modification thereof, in accordance with R9-21-315;
   e. Of the authority of the Department to require necessary and relevant information about the individual's needs, income, and resources;
   f. Of the availability of assistance from the regional authority in obtaining information necessary to determine the need for mental health services;
   g. Of the authority of the Department or mental health agency to charge for services and assessments; and
   h. That if they decline the services of a case manager or an ISP, they have the right to apply for services at a subsequent time;
   i. That if they decline any particular service or treatment modality, it will not jeopardize other accepted services.

E. Extensions of time.
1. The case manager may extend the time to initiate or complete eligibility determinations, assessments, ISPs, and other actions pursuant to this Article if:
   a. There is substantial difficulty in scheduling a meeting at which all necessary participants can attend;
   b. The client fails to keep an appointment for assessment, evaluation, or any other necessary meeting;
   c. The client is capable of but temporarily refuses to cooperate in the preparation of the plan or completion of an assessment or evaluation; or
   d. The client or the client's guardian and/or designated representative requests an extension of time.
2. An extension under this rule shall not exceed the number of days incurred by the delay and in no event may exceed 20 days, unless the whereabouts of the client are unknown.

F. Meeting attendance through telecommunications link. Attendance by any person at any meeting which is required or recommended pursuant to this Article may be accomplished through a telecommunications link which is contemporaneous with the meeting.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-21-302. Identification, Application, and Referral for Services of Persons with Serious Mental Illness

A. Each regional authority shall develop and implement outreach programs that identify individuals within the authority's geographic area, including persons who reside in jails, homeless shelters, or other settings, who are seriously mentally ill.

1. Inpatient facilities shall identify individuals in their respective facilities who are seriously mentally ill.
2. An individual identified under this subsection shall be referred in writing to the appropriate regional authority for a determination of eligibility as provided in this Article.

B. An individual desiring mental health services under this Article may apply to the appropriate regional authority for a determination of eligibility. Application may be made by the individual or on the individual's behalf by the person's guardian, designated representative, or other appropriate individuals such as a family member or staff of a mental health agency. Individuals may apply for community mental health services regardless of whether they reside in the community, an inpatient facility, a county jail, a homeless shelter, or any other location within the state of Arizona.

C. Upon application or referral for services, all individuals shall be provided a client rights brochure and the notices required by R9-21-211.

D. Upon receipt of an application or referral for services the regional authority shall assign a case manager and clinical team to the applicant within three days.

Historical Note

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R9-21-303. Eligibility: Interview and Determination

A. Within three days of receipt of an application or referral by the regional authority, a qualified clinician shall meet with the individual, unless the individual refuses to be interviewed or is otherwise unavailable, to determine whether the individual is eligible for services under this Article.
1. The clinician shall provide the individual all of the information required by R9-21-301(D).
2. The clinician shall schedule the applicant for a mental status examination, including an evaluation of the individual's decision-making capacity, to assist in the eligibility determination.

B. The qualified clinician shall gather other necessary information to make an eligibility determination, including:
1. Identifying data and residence, including a social security number if available;
2. The reasons for the request or referral for services;
3. The individual's psychiatric diagnosis;
4. The individual's present level of functioning, based upon the criteria set forth in the definition of "seriously mentally ill" in R9-21-101;
5. The individual's history of mental health treatment;
6. The individual's abilities, needs, and preferences for services; and
7. A preliminary determination as to the individual's need for special assistance as defined by R9-21-101(B)(9).

C. If at any time during the course of the eligibility process the qualified clinician determines that the individual has a current case manager, a current assessment, or an ISP, the clinician shall notify the client's case manager and terminate the eligibility process.

D. Within seven days of receipt of an application or referral by the regional authority, a qualified clinician shall determine whether an individual is eligible for mental health services under this Article. In making the determination of eligibility, the qualified clinician shall consider all of the information available, including the results of the mental health status examination.

E. To be eligible for community services pursuant to this Article the individual must be:
1. A resident of the state of Arizona, and
2. Seriously mentally ill as defined in R9-21-101.

F. Within two days of the eligibility determination, the qualified clinician shall provide written notice of the decision to the individual and shall inform any person who is deemed ineligible for mental health services that:
1. The person can appeal pursuant to R9-21-315,
2. The person can reapply at a later time, and
3. The person may request assistance in obtaining other services and will be provided a referral to an appropriate agency.

G. Nothing in this rule shall be construed to require the qualified clinician to make the determination of whether the applicant is eligible for services under Arizona Health Care Cost Containment System Administration (AHCCCSA) pursuant to A.R.S. Title 36, Chapter 29.

Historical Note

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R9-21-304. Provisional and Emergency Services

A. After the determination of eligibility but prior to the development and acceptance of the ISP, the case manager shall, with the consent of the client, identify and provide provisional services which are consistent with the client's preferences and needs.

B. In the case of referral for provisional services, subject to the requirements of any applicable contract with the Department, the service provider may:
1. Accept the client; or
2. In non-emergency situations, reject the client for good cause due to the inability of the service provider to safely and professionally meet the client's needs. The service provider shall inform the case manager within 24 hours of such rejection and the reasons therefor. The case manager shall refer the client to other provisional services, if appropriate and available or believed to be soon available, or shall refer the matter to the director of the agency providing case management.

C. If a qualified clinician determines that an emergency exists necessitating immediate intervention, emergency or crisis services shall be provided immediately.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

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R9-21-305. Assessments

A. General Provisions.
1. Within five days of a determination of eligibility, the case manager shall initiate an assessment of the client's strengths and needs by the clinical team. The case manager may arrange for the inclusion of other persons, including appropriate mental health or other professionals, with the client's consent and to the extent necessary to ensure that the assessment is comprehensive.
2. The assessment shall include:
   a. A personal interview with the client by a qualified clinician or case manager, if one was not conducted during the eligibility process, including a determination of the client's preferences regarding services;
   b. An analysis of reliable written information such as the client's clinical history, records, tests and other evaluations;
   c. The collection of additional information, as needed, in each of the areas set forth in subsection (B) below; and
   d. A review of information from family, friends and others, as appropriate.
3. The assessment may be based in part on information obtained in the course of the eligibility process required by R9-21-303.

B. The assessment shall evaluate, without regard to the availability of services, but with due regard to the client's circumstances and the availability of information to the clinical team, the following areas:
1. The client's mental health status, including:
   a. Cognitive functioning, including attention, memory, information processing, and problem solving;
   b. Affect, attitudes, self-image, emotional stability, and mood;
   c. Interpersonal relations, social adjustment, and interests;
   d. Behavioral symptoms;
   e. The history of any diagnosed mental illness;
   f. Documentation of the need for medication;
   g. Emotional and behavioral health history; and
   h. Substance abuse history.
2. The client's legal status and/or apparent capacity, including:
   a. The existence of a guardianship or conservatorship for the client, including the court and date of appointment of the guardian or conservator, the name and address of the guardian or conservator, and the scope of the authority of the guardian or conservator;
   b. Whether the client appears:
      i. Capable of making informed decisions with regard to medical care or other treatment, financial matters, or confidential information;
      ii. Able to effectively participate in the service planning process; and
      iii. Able to exercise other rights and privileges set forth in Articles 2 and 4 of these rules;
   c. Consistent with the standards and procedures of R9-21-206(C), whether the client needs a guardianship, conservatorship, representative payee, or other protective services under A.R.S. § 14-5101, 14-5401 or, 36-547 et seq.; or, in the alternative, whether the client is no longer in need of such protective services;
   d. Whether the client needs or would benefit from special assistance, counsel or advice in making treatment decisions or in enforcing the client's rights; and
   e. The existence of any type of court-ordered treatment.
3. The client's social setting, including his/her current living situation, neighborhood, community, family, and key support persons.
4. The client's health, including a physical examination and other evaluations, as appropriate, of the client's medical and dental condition, with documentation of any chronic medical condition which requires regular monitoring or intervention. No physical examination shall be conducted over a client's refusal unless consent is given by the client's guardian or the examination is provided for by court order. If there is documentation of the results of a physical examination conducted within the past year, no further examination is required, unless medically indicated.
5. The client's level of daily living skills in:
   a. Personal care and grooming, nutrition and food preparation, and domestic skills;
   b. Health maintenance, hazard recognition and avoidance, and ability to follow a prescribed treatment program, including medication;
   c. Time and money management and the utilization of community resources;
   d. Communication, functional reading, the use of a telephone, and the ability to independently request assistance; and
   e. Self-preservation and the ability to promptly exit a building in the event of a fire.
6. The client's criminal justice history.
7. The client's vocational and employment skills and potential, including any vocational history, an evaluation of work skills, and the client's preferences and interests in employment.
8. The clients education and training, including a history or evaluation, as appropriate, of the client's educational background, current education plan, or Individual Education Plan (IEP), if any.
9. The client's language abilities, including an identification of the client's ability to read, hear, understand, and speak English using complex sentences, and of the client's preferred language.
10. The client's resources, including the identification of public and private resources paid to or for the client or to

which the client may be entitled under any local, state or federal law or regulations including:

a. Income maintenance programs, such as Supplemental Security Income, Social Security Disability Insurance, Workers' Compensation, Unemployment Compensation, Veterans' Administration, Food Stamps, and/or General Assistance;
b. If resources are available and subject to the control of a representative payee, the name and address of the representative payee and the specific agency or office with responsibility for the representative payee;
c. Benefits or income from any trust, including the court, if any, with responsibility for overseeing the operation of the trust, the name and address of the trustee, and the terms of the trust;
d. Health care benefits, such as from the AHCCCSA, Medicare, or individual, group, or family health insurance;
e. Housing assistance, including eligibility for public housing, rental assistance, and subsidized housing;.
f. Educational/vocational services, such as special education, vocational rehabilitation services, employment counseling and placement services, or special training and placement available to the client; and
g. Social services, including those under Title XIX and those administered by private, local, and state social service agencies.

11. The client's substance abuse history.

C. Within 20 days of the initiation of the assessment, the case manager shall prepare the assessment report. The report shall include:

1. The development of a long-term view by the client with assistance from the clinical team that establishes a method of integration for living, employment and social conditions that the client wishes to achieve over the next three years;
2. A summary of the information gathered during the eligibility and assessment processes;
3. An identification of the client's legal status, resources, and assessed strengths and actual needs, regardless of the availability of services to meet that need, in each area of assessment identified in subsection (B) above;
4. An analysis of the major findings of the mental health assessment, including a description of the nature and severity of any illness and a diagnosis in terms set forth in the DSM;
5. The client's preferences regarding services to be provided;
6. A description of any provisional services which are required and plans for the referral of the client to provisional services or the continuation of provisional services already provided;
7. An identification of further evaluations which the clinical team deem necessary to determine the services appropriate to the client's needs;
8. An identification of assessments which could not be completed due to the client's circumstances or the unavailability of information; and
9. A functional assessment of the client's current status in terms of independent living, employment (or retirement), and social integration and analysis of the support or skills, if any, necessary to achieve the client's long-term view.

D. The case manager shall arrange for any further evaluations recommended by the clinical team. If the client needs assessment in an area beyond the ability or expertise of the clinical team, such assessment shall be conducted with the client's consent by professionals with appropriate credentials. The need for further evaluations shall not unreasonably delay the preparation of the ISP, except with the client's consent.

E. If, as a result of the assessment of legal status or apparent capacity, it is determined that the client requires special assistance in asserting or protecting rights under these rules, the case manager shall:

1. Notify the regional authority, the Office of Human Rights, and the appropriate human rights committees of the client's need so that the client can be provided special assistance from the human rights advocate or special review by the human rights committee; and
2. If the client does not have a guardian, identify a friend, relative or other person who is willing to serve as a designated representative of the client.

F. Upon completion of the assessment report, copies shall be sent to the client, the designated representative, if any, the guardian, and all service providers who have been identified by the case manager or regional authority to serve the client.

Historical Note

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R9-21-306. Identification of Potential Service Providers

A. As soon as needs of the client for particular services are identified through the eligibility determination, assessment, or further evaluation processes, the clinical team in conjunction with the client shall begin considering and choosing potential service providers to participate in the development of the client's ISP.

1. Within five days of the completion of the assessment report, the clinical team and the client shall have completed the identification of those service providers most appropriate to meet the client's needs as identified in the report.
2. The case manager shall promptly contact the identified providers to determine their ability to serve the client.
3. Within ten days of the completion of the assessment report, the case manager shall request identified providers able to serve the client to participate in the development of the client's Individual Service Plan. All identified providers shall be provided notice of the time and place of the ISP meeting.

B. The clinical team, in conjunction with the client, shall determine which provider(s) are the most appropriate to serve the client. The determination of appropriateness shall consider:

1. The client's preferences for the type, intensity, and location of services;
2. The capacity and experience of the provider in meeting the client's assessed needs;
3. The proximity of the provider to the client's family and home community;
4. The availability and quality of services offered by the provider; and
5. Other factors deemed relevant by the case manager and clinical team.

C. The clinical team shall provide sufficient information to the identified service providers to allow them to understand the client's long-term view, strengths, needs, and required services and to take an active role in the ISP meeting.

D. All mental health agencies currently providing services to the client shall bring to the ISP meeting a written description of the nature, type, and frequency of services provided or to be provided by the agency.

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R9-21-307. The Individual Service Plan

A. General provisions.

1. An individual service plan (ISP) shall be developed by the clinical team and each client.
2. The ISP shall include the most appropriate and least restrictive services, consistent with the client's needs and preferences, as identified in the assessment conducted pursuant to R9-21-305, and without regard to the availability of services or resources.
3. The ISP shall identify those services which maximize the client's strengths, independence, and integration into the community.
4. Generic services available to the general public should be utilized, to the maximum extent possible, when adequate to meet the client's needs and if access can be arranged by the case manager or client.
5. If all needed services are not available, a plan for interim services shall detail those services which are, to the maximum extent possible, adequate, appropriate, consistent with the client's needs, and least restrictive of the client's freedom.
6. The clinical team shall solicit and actively encourage the participation of the client and guardian.
7. The clinical team shall inform the client of the right to have a designated representative throughout the ISP process and to invite family members or other persons who could contribute to the development of the ISP. The case manager shall seek to obtain a representative for clients who need special assistance or otherwise have limited capacity to articulate their own preferences and to protect their own interests in the ISP process and shall advise the relevant human rights committee that the client has been determined to need special assistance.
8. The ISP shall contain goals and objectives which are measurable and which facilitate meaningful evaluation of the progress toward attaining those goals and objectives.
9. The ISP shall incorporate a specific description of the client objectives, services, and interventions for each mental health agency which will provide services to the client. Each existing service provider will bring to the ISP meeting a detailed written description of the objectives and services currently in effect for the client.
10. For residents of an inpatient facility, the facility's treatment and discharge plan shall be developed pursuant to R9-21-312 and shall be incorporated in the ISP.
11. Prior to the planned discharge of a new client from an inpatient facility, the clinical team shall develop an ISP which describes the community services, including alternative housing and residential supports, that will be provided when the client leaves the facility.
12. The ISP shall be written in language which can be easily understood by a lay person.
13. In developing the ISP, the case manager shall facilitate resolution of differences among service providers and, if resolution is not achieved, shall refer the matter to the regional authority, which shall resolve the matter in accordance with Department policy.

B. The individual service plan meeting.

1. Within 20 days of the completion of the assessment report, the case manager shall convene an ISP meeting at a convenient time and place for the client, guardian, clinical team, and potential service providers.
2. The case manager shall arrange for the client's transportation, if needed, to the ISP meeting.
3. The case manager shall notify in writing the following persons of the time, date and location of the ISP meeting at least ten days prior:
   a. The client, any designated representative and guardian, including an invitation to submit relevant information in writing if their attendance is impossible;
   b. Clinicians involved in the assessment or further evaluation;
   c. All current and potential service providers;
   d. All members of the client's clinical team;
   e. Family members, with the client's consent;
   f. Other persons familiar with the client whose presence at the meeting is requested by the client;
   g. Any other person whose participation is not objected to by the client and who, in the judgment of the case manager, will contribute to the ISP.
4. The case manager shall chair the ISP meeting which shall include a discussion of:
   a. The client's supports or skills necessary to achieve the client's long-term view in each of the areas listed in R9-21-305(B);
   b. The findings and conclusions contained in the eligibility determination, assessment report, and further evaluations, including a list of further evaluations to be completed;
   c. Any existing ITDP pursuant to R9-21-312;
   d. The client's preferences regarding services;
   e. Recommended long-term or interim services;
   f. Current or proposed service providers, including the need to have service providers with staff who have

language and communications skills other than English if necessary to communicate with the client;
g. Recommended dates for commencement of each service or date each service commenced;
h. The methods and persons to ensure that services are provided as set forth in the ISP, adequately coordinated, and regularly monitored for effectiveness;
i. The procedure for completion and implementation of the ISP process, including the procedures for accepting, rejecting, or appealing the ISP; and
j. The procedure for clients or service providers to request changes in the ISP.

C. The individual service plan shall include:
1. A description of the client's long-term view and the client's preferences, strengths, and needs in all relevant areas listed in R9-21-305(B), including present functioning level and medical condition, with documentation of any chronic medical condition which requires regular monitoring or intervention.
2. A description of the most appropriate and least restrictive services consistent with the client's needs and without reference to existing resources.
3. A statement of whether the client requires service providers with staff who are competent in any language other than English in order to communicate with the client.
4. Target dates for commencement of each service or date each service commenced and their anticipated duration.
5. Long range goals for each service which will assist the client in attaining the most self-fulfilling, age-appropriate, and independent style of living possible for the client, consistent with the client's preference, stated in terms which allow objective measurement of progress and which the client, to the maximum extent possible, both understands and adopts.
6. Short-term objectives that lead to attainment of overall goals stated in terms which allow objective measurement of progress and which the client, to the maximum extent possible, both understands and accepts.
7. Expected dates of completion for each objective;
8. Persons and service providers responsible for each objective.
9. Identification of each generic or service provider responsible for providing the specific service required to meet each of the client's needs, including the name and address and telephone number of the provider and the location where the service will be provided.
10. A detailed description of the client objectives and services for each mental health agency which will provide services to the client.
11. Identification of any need for alternative housing or residential setting, including the support and monitoring to be provided after any change in housing or residential setting as provided in R9-21-310(D).
12. Based upon assessments and other available information, a determination of:
    a. The client's capacity to:
        i. Make competent decisions on matters such as medical and mental health treatment, finances, and releasing confidential information;
        ii. Participate in the development of the ISP; and
        iii. Independently exercise the client's rights under this Chapter.
    b. The client's need for guardianship or other protective services or assistance.
    c. The client's need for special assistance.
13. A list of the assessments which were not completed due to the client's current mental or physical condition or due to the clinical team's inability to access records together with a statement of the causes and plans to obtain these assessments.
14. A description of the methods and persons responsible for ensuring that services are:
    a. Provided as set forth in the ISP;
    b. Adequately coordinated; and
    c. Regularly monitored for effectiveness.
15. A statement of the right of the client, designated representative, or guardian to accept or reject the ISP, request other services, or appeal the ISP or any aspect thereof.
16. A statement that the client's acceptance of the ISP constitutes consent to the services enumerated therein.

D. Preparation and distribution of the individual service plan.
1. Within seven days of the ISP meeting, the case manager shall prepare and distribute the ISP as provided herein.
2. The case manager or other clinical team member shall personally deliver to and review the ISP with the client.
3. The ISP shall be mailed or otherwise distributed to the following persons:
    a. The client's designated representative and/or guardian;
    b. The members of the clinical team; and
    c. All existing or potential service providers.

Historical Note
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R9-21-308. Acceptance or Rejection of the Individual Service Plan

A. Within seven days of the distribution of the ISP, the case manager shall contact the client concerning acceptance or rejection of all or any portion of the ISP, or request for other services, if there has not been acceptance, rejection or a request prior to that date.

B. If the client or guardian does not object to the ISP within 30 days of receipt of the plan, the client shall be deemed to have accepted the ISP.

C. If the client or guardian rejects some or all of the services identified in the ISP, or requests other services, the case manager shall provide written notice to the client or guardian of the right to immediately appeal the ISP pursuant to R9-21-315 or to meet with the clinical team within seven days of the rejection to discuss the plan and suggest modifications. The case manager shall arrange the meeting at a convenient time and place for the client, any designated representative and/or guardian, and the clinical team.

D. If the client's proposed modifications are adopted by the clinical team, the case manager shall arrange for approval of the modifications by all service providers.

E. If the matter is not resolved to the client's or guardian's satisfaction, the case manager shall again inform the client or guardian of the right to appeal the ISP.

F. A client or guardian who rejects the ISP may accept some or all of the identified services pending the outcome of the meeting with the clinical team or an appeal.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-21-309. Selection of Service Providers

A. Within seven days of the distribution of the ISP to the service providers identified in the ISP, the case manager, after consultation with the clinical team and the provider, shall determine whether each of these providers are capable of serving the client.

1. A service provider shall not refuse to serve a client except for good cause related to the inability of the service provider to safely and professionally meet the client's needs as set forth in the ISP, or except for Department contractual limitations.
2. If a service provider believes it is incapable of meeting the client's needs or of implementing the ISP, the provider shall so inform the case manager in writing within five days of receipt of the ISP. A service provider must specify the reasons for its conclusion.

B. If it is determined by the clinical team that a housing, residential or vocational service provider identified in the ISP is not capable of serving the client, the case manager shall, with the approval of the clinical team, identify another provider who is qualified to provide the services set forth in the client's ISP, introduce the client to the new service provider, and modify the ISP as needed.

C. If the clinical team determines that an identified provider, other than a housing, residential or vocational service provider, is not capable of serving a client, the case manager shall, with the approval of the clinical team, identify another provider which is qualified to provide the services set forth in the client's ISP. The case manager shall promptly distribute the ISP to such alternative service provider.

D. All selected service providers shall sign the ISP and implement the identified services.

Historical Note

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R9-21-310. Implementation of the Individual Service Plan

A. Upon acceptance of the ISP by the client or as defined in a court order, services shall be initiated in accordance with the timetable set forth in the ISP.

B. If all or a portion of the ISP is rejected by the client or guardian, the plan will not be implemented nor services provided unless the client or guardian consents to specific services.

C. For each client who is identified as needing alternative housing, a new residential setting, or a residential support service, the case manager shall inform the client of the need for an alternative living arrangement and shall use his or her best efforts to obtain appropriate housing or residential supports. These efforts may include showing the client the house or apartment in which the client could reside, introducing the client to other residents of the residential setting, as appropriate, and permitting the client to live in the alternative setting on a trial basis. All clients shall be informed that they may elect to move at any time in the future subject to the terms of any lease, mortgage, contract, or other legal agreement between the client and the housing provider.

D. For at least the first two months after an client moves to a new residential setting, the case manager shall coordinate and monitor support services, as set forth in the client's ISP, in order to foster the maintenance of the client's key relationships with others, to provide necessary orientation, and to ensure a smooth and successful transition into the new setting.

E. All contracts with service providers shall include:

1. A provision that the service provider will abide by the rules contained in this Chapter and will not alter, terminate, or otherwise interrupt services required under the ISP except where the ISP has been modified pursuant to R9-21-314;
2. A provision that the service provider will cooperate with the Department in collecting data necessary to determine if the Department is meeting its obligations under this Chapter and A.R.S. § 36-550 et seq.; and
3. A provision that the service provider agrees to maintain current client records which document progress toward achievement of ISP goals and objectives and which meet applicable requirements of law, contract, and professional standards.

Historical Note

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Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-311. Interim Services

A. If the services identified in the ISP are not currently available, the clinical team shall develop an alternative plan for interim services, based upon the client's strengths, needs, and preferences as set forth in the assessment conducted pursuant to R9-21-305. The plan for interim services shall be developed after the preparation of the ISP.

B. The plan for interim services shall be developed pursuant to the same procedures for the preparation of an ISP and may be developed at the same meeting with the ISP if the clinical team is aware that appropriate services are not currently available. If at an ISP meeting the clinical team does not know whether the appropriate services are available, the clinical team shall use diligent efforts to locate the identified services. If appropriate services are determined to be unavailable, the ISP meeting shall be reconvened to develop an interim ISP.

C. The plan for interim services shall identify those available mental health and generic services which are, to the maximum extent possible, adequate, appropriate, consistent with the client's needs and least restrictive of the client's freedom.

D. The plan for interim services shall contain a list of appropriate but unavailable services and the projected date for the initiation of each service.

E. If the clinical team determines that a recommended service is unavailable or does not exist, it shall forward a description of that service to the director of the regional authority. The director shall:

1. Use best efforts to locate the needed service through existing services or reallocated resources;
2. Forward a description of the unmet service need to the deputy director of the Division, if the appropriate service cannot be located or developed through existing services or reallocated resources; and
3. maintain a list of unmet service needs.

F. The Division shall use information concerning unmet service needs to provide the appropriate service through existing services or reallocated resources or, if necessary, to plan for the development of the needed services.

G. Nothing in this rule shall effect or modify any provision of Arizona law with respect to a client's right to appropriate services.

Historical Note

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R9-21-312. Inpatient Treatment and Discharge Plan

A. General provisions.

1. Every client of an inpatient facility shall have a Inpatient Treatment and Discharge Plan (ITDP).
2. An ITDP shall be developed by the inpatient facility's treatment team, the case manager and other members of the clinical team, as appropriate.
3. The ITDP shall include the most appropriate and least restrictive services available at the inpatient facility, as well as a plan for the client's discharge to the community.
4. The ITDP shall identify those treatment interventions and services which maximize the client's strengths, independence, and integration into the community.
5. The ITDP shall be developed with the fullest possible participation of the client and any designated representative and/or guardian.
6. The ITDP shall contain goals and objectives which are measurable and which facilitate meaningful evaluation of the progress toward attaining those goals and objectives.
7. The ITDP shall be written in language which can be easily understood by a lay person.
8. Delays in the assignment of a case manager or in the development or modification of an ISP or ITDP shall not be construed to prevent the appropriate discharge of a client from an inpatient facility.

B. The individual treatment and discharge plan meeting.

1. The case manager shall encourage the client to have a designated representative assist the client at the meeting and to have other persons, including family members, attend the meeting. The case manager shall ensure that the human rights advocate is notified of the time and date of the ITDP for clients who need special assistance.
2. The following persons shall be invited to attend the ITDP meeting:
   a. The client;
   b. Any designated representative and/or guardian;
   c. Family members, with the client's consent;
   d. Members of the client's inpatient facility treatment team;
   e. The case manager and other members of the clinical team, as appropriate;
   f. Other persons familiar with the client whose presence at the meeting is requested by the client; and
   g. Any other person whose participation is not objected to by the client and who will, in the judgment of the case manager, contribute to the ITDP meeting.
3. The ITDP meeting shall include a discussion of:
   a. A review of the ISP's long-term view;
   b. If necessary, a new functional assessment of the supports or skills necessary to achieve the client's long-term view;
   c. The client's needs in terms of assessed strengths and needs;
   d. The client's preferences regarding services;
   e. Existing services if any;
   f. The procedure for completion and implementation of the ITDP process, including the procedures for accepting, rejecting, or appealing the ITDP;
   g. The procedure for clients or the inpatient facility to request changes in the ITDP; and
   h. The methods to ensure that services are provided as set forth in the ITDP and regularly monitored for effectiveness.

C. Inpatient treatment and discharge plan.

1. The facility treatment team, the case manager, and other representatives of the clinical team, as appropriate, shall develop a preliminary ITDP within three days, and a full

ITDP within seven days thereafter, of the client's admission. Where a client's anticipated stay is less than seven days, an acute inpatient facility shall develop a preliminary ITDP within one day and a full ITDP within three days of a client's admission.

2. The ITDP shall be consistent with the goals, objectives, and services set forth in the client's ISP and shall be incorporated into the ISP.
3. The ITDP shall include:
   a. The client's preferences, strengths, and needs;
   b. A description of appropriate services to meet the client's needs;
   c. For non-acute facilities, long-range goals which will assist the client in attaining the most self-fulfilling, age-appropriate, and independent style of living possible, stated in terms which allow objective measurement of progress and which the client, to the maximum extent possible, both understands and accepts;
   d. Short-term objectives that lead to attainment of overall goals stated in terms which allow objective measurement of progress and which the client, to the maximum extent possible, both understands and accepts;
   e. Expected dates of completion for each objective;
   f. Persons responsible for each objective;
   g. The person responsible for ensuring that services are actually provided and are regularly monitored; and
   h. The right of the client or guardian to accept or reject the ITDP, request other services, or appeal the ITDP or any aspect thereof.

D. Preparation and distribution of the ITDP.
1. Within three days of the ITDP meeting, the treatment team coordinator shall prepare and distribute the ITDP.
2. The ITDP shall be personally presented and explained to the client by the case manager.
3. The ITDP shall be mailed or otherwise distributed to the following persons:
   a. The client's designated representative and guardian, if any;
   b. The case manager and members of the clinical team; and
   c. The members of the inpatient facility's treatment team.

E. Acceptance or rejection of the ITDP.
1. Within two days of the date when the ITDP was distributed, the client shall be contacted by the case manager concerning acceptance or rejection of the ITDP, if there has not been acceptance or rejection prior to that date.
2. If the client or guardian does not object to the ITDP within ten days of the date when the ITDP was distributed, the client shall be deemed to have accepted the ITDP.
3. If the client or guardian rejects some or all of the treatment interventions or services identified in the ITDP or requests other services, the case manager shall provide written notice to the client of the right to meet with the treatment team coordinator within five days of the rejection to discuss the plan and to suggest modifications, or to immediately appeal the plan pursuant to R9-21-315.
4. If modifications are agreed to by the treatment team coordinator and the client or guardian, the treatment team coordinator shall arrange for approval of the modifications by all members of the inpatient facility's treatment team, the case manager, and members of the clinical team, as appropriate.
5. If the matter is not resolved to the client's or guardian's satisfaction, the case manager shall again inform the client and guardian of the right to appeal pursuant to R9-21-315. The client or guardian may appeal findings or recommendations in the ITDP within 30 days of receipt of the plan.
6. A client or guardian who rejects the ITDP may accept some or all of the identified treatment interventions or services pending the outcome of the meeting with the treatment team coordinator or an appeal.

F. The updated ITDP. The facility treatment team, the case manager, and other representatives of the clinical team, as appropriate, shall review the ITDP as frequently as necessary, but at least once within the first 30 days of completing the plan, every 60 days thereafter during the first year, and every 90 days thereafter during any subsequent years that the client remains a resident of the facility.

G. Incorporation into the individual service plan.
1. If the clinical team determines that the ITDP is appropriate to meet the client's needs, least restrictive of the client's freedom, and consistent with the ISP, it shall approve the ITDP by incorporating it into the ISP. If the clinical team disapproves the ITDP, it shall convene an ISP meeting, which includes the inpatient facility treatment team, to prepare a revised ITDP.
2. The clinical team, with the assistance of the inpatient facility's treatment team, shall be responsible for implementing the plan for the client's discharge.
3. The case manager will provide notice to those providers identified in the client's ISP three days prior to the client's actual discharge, except that the failure to provide such notice shall not delay discharge.
4. The case manager shall meet with the client within five days of the client's discharge to ensure that the ISP is being implemented.
5. The case manager shall review the ISP with the clinical team within 30 days of the discharge to determine whether any modifications are appropriate, consistent with the standards and requirements set forth in R9-21-314.

Historical Note

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R9-21-313. Periodic Review of Individual Service Plans

A. General provisions.
1. Where an ISP includes residential, vocational, or other primary service providers that do not currently serve the client, the first ISP review shall be held within 30 days from the date on which all such providers have initiated

services to client. Each service provider shall bring to the review a detailed description of the objectives and services currently in effect for the client.

2. Where the ISP includes only primary service providers that currently serve the client, the first ISP review shall be held within six months of the date the ISP is accepted by the client or the date on which any appeal is concluded.
3. Thereafter, ISP reviews shall be conducted at least every six months and more frequently as needed. The ISP review shall be chaired by the case manager.
4. The purpose of the ISP review is to ensure that services continue to be, to the maximum extent possible, appropriate to the client's needs and least restrictive of the client's freedom.
5. The review shall be conducted with the fullest possible participation of the client and any designated representative and/or guardian.

B. The ISP review.

1. At least ten days prior to the ISP review meeting, the case manager shall invite, in writing, the following persons to attend the meeting:
   a. The client and any designated representative and/or guardian;
   b. Family members, with the consent of the client;
   c. Members of the client's clinical team;
   d. Representatives of each of the client's service providers;
   e. Any other person familiar with the client whose participation is requested by the client; and
   f. Any other person whose participation is not refused by the client and who, in the judgment of the case manager, will contribute to the ISP review.
2. The ISP review shall, to the extent possible given the circumstances of the client and the availability of information, consider:
   a. Whether there has been any change in the clinical, social, training, medical, vocational, educational and personal needs of the client;
   b. Whether the client needs any further assessment or evaluations;
   c. Whether the services being provided to the client continue to be appropriate to meet the client's needs, least restrictive of the client's freedom, consistent with the client's preferences, and as integrated as possible in the client's home community;
   d. Whether there has been progress towards attainment of the long-term view, and each of the goals and objectives stated in the ISP;
   e. Whether to reaffirm, modify or delete each goal and objective, together with the reasons for these actions;
   f. Whether there has been any change in the legal status of the client, in the necessity or advisability of having a guardian or conservator appointed or removed, or in the client's need for special assistance;
   g. Whether any change in the client's circumstances should result in a modification of the client's priority of need for services not currently provided; and
   h. Whether there has been any change in the availability of services formerly determined to be needed but not then available.
3. The client, any designated representative and/or guardian, and clinical team will review each service provider's detailed description of current objectives and services to determine whether it is consistent with client's needs, least restrictive of the client's freedom, and designed to maximize the client's independence and integration into the community.
   a. If the detailed description is approved and accepted by the client, any designated representative and/or guardian, and the clinical team, it shall be incorporated into the updated ISP.
   b. If the description of services is rejected, it shall be revised with the assistance of the service provider and, as revised, incorporated into the updated ISP.

C. The updated ISP.

1. Within seven days of the ISP review meeting, the case manager shall prepare an updated ISP which includes all of the elements set forth in R9-21-307(C).
2. The case manager shall personally meet with the client or guardian to explain the updated ISP. The updated ISP shall be mailed or otherwise distributed to the other participants of the review meeting.
3. The updated ISP is subject to the client acceptance, rejection, and requests for other service provisions of R9-21-308 and the appeal provisions of R9-21-315.
4. The updated ISP shall be implemented consistent with the provisions of R9-21-310.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-21-314. Modification or Termination of Plans

A. Requests for modifications or termination of an ISP or any portion thereof may be initiated at the ISP review or at any other time by:

1. The client;
2. Any designated representative and/or guardian;
3. A service provider; or
4. Any member of the clinical team.

B. A request for modification or termination of an ISP shall be directed to the case manager.

C. The case manager shall give the client, the client's guardian and designated representative, appropriate service providers, and the client's clinical team written notice of any request for modification or termination of the ISP.

D. An ISP may be modified in order to more appropriately meet the client's needs, goals, and objectives. An ISP shall be modified where:

1. The client withdraws consent to the ISP or any portion thereof;
2. The client consents to services recommended as more suitable but previously refused by the client;
3. The needs of the client have changed due to progress or lack of progress in meeting the client's goals and objectives;

4. The proposed change will permit the client to receive services which are more consistent with the client's needs, less restrictive of the client's freedom, more integrated in the community, or more likely to maximize the client's ability to live independently;
5. The client wants to change the long-term view and the focus of the ISP or no longer needs a service or services; or
6. The client is no longer eligible for services pursuant to R9-21-303.

E. The clinical team shall:
1. Be notified by a service provider of any proposed termination or modification of services in the ISP as soon as possible and always prior to its implementation;
2. Promptly inform the client and any designated representative and/or guardian of the requested modification and seek the client's consent to implement such modification or termination; and
3. Within 20 days of any request for modification or termination of an ISP, approve the request only if the request meets the requirements of subsection (D).
4. Provide written notice of the right to appeal to the client and any designated representative and guardian in accordance with R9-21-315(B) whenever service to the client is to be terminated, suspended or reduced.

F. The case manager shall:
1. Incorporate the approved modification in the current ISP or prepare a revised ISP, as appropriate.
2. Within five days of any approval by the clinical team, distribute the modified or revised ISP to the client, any designated representative and/or guardian, the members of the clinical team, and all service providers.
3. Meet with the client or guardian to explain the modification or revision and the client's right to appeal pursuant to R9-21-315.

G. If the client or any designated representative and/or guardian does not reject or appeal the termination or modification within 30 days of the date the modified ISP is distributed, the client shall be deemed to have accepted the termination or modification.

H. The client for whom a modification or termination is proposed or any designated representative and/or guardian may appeal a modification or termination pursuant to R9-21-315.

I. If the clinical team denies the client's or guardian's request to modify or terminate an ISP, the client or the designated representative and/or guardian may appeal the denial pursuant to R9-21-315.

J. No modification or termination of an ISP shall be made without the acceptance of the client or any designated representative and/or guardian, unless a qualified clinician determines that the modification or termination is required to avoid a serious or immediate threat to the health or safety of the client or others.
1. Except in an emergency, no requested termination of a client from a particular service or provider may be considered unless the standards and procedures set forth in R9-21-210 and the provisions of this rule are satisfied.
2. The client may not be transferred from one program or location to another while an appeal is pending.

K. If the case manager determines that the client is no longer eligible for services pursuant to R9-21-303, the case manager shall make a determination of non-eligibility, move to terminate services under the ISP and this rule, and notify in writing the client of the non-eligibility determination and of the right to appeal such determination, in accordance with R9-21-315. When appropriate, referral and provision for further treatment shall be made by the case manager or clinical team.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-21-315. Appeals

A. A client or applicant may file an appeal concerning decisions regarding eligibility for mental health services, including Title XIX services, fees and waivers; assessments and further evaluations; service and treatment plans and planning decisions; and the implementation of those decisions. Appeals regarding a determination of categorical ineligibility for Title XIX shall be directed to the agency which made that determination.
1. Disagreements among employees of the Department, the regional authority, clinical teams, and service providers concerning services, placement, or other issues are to be resolved using Departmental guidelines, rather than this rule.
2. The case manager shall attempt to resolve disagreements prior to utilizing this appeal procedure; however, the client's right to file an appeal shall not be interfered with by any mental health agency or the Department.
3. The Office of Human Rights shall assist clients in resolving appeals pursuant to R9-21-105.

B. Applicants and clients shall be informed of their right to appeal at the time an application for services is made, when an eligibility determination is made, when a decision regarding fees or the waiver thereof is made, upon receipt of the assessment report, during the ISP, ITDP, and review meetings, at the time an ISP, ITDP, and any modification thereto is distributed, when any service is suspended or terminated, and at such other times set forth in this Article. The notice shall be in writing in English and Spanish and shall include:
1. The client's right to appeal and to a fair hearing pursuant to R9-21-315;
2. The method by which an appeal and fair hearing may be obtained;
3. That the client may represent himself or use legal counsel or other appropriate representative;
4. The services available to assist the client from the Office of Human Rights, Human Rights Committees, State Protection and Advocacy System, and other peer support and advocacy services;
5. What action the mental health agency or Department intends to take;
6. The reasons for the intended action;
7. The specific rules or laws that support such action; and
8. An explanation of the circumstances under which services will continue if an appeal or fair hearing is requested.

C. The right to appeal created herein does not include the right to appeal a court order entered pursuant to A.R.S. Title 36, Chapter 5, Articles 4 and 5. The following issues may be appealed:
1. Decisions regarding the individual's eligibility for mental health services;
2. The sufficiency or appropriateness of the assessment or any further evaluation;
3. The long-term view, service goals, objectives, or timelines stated in the ISP or ITDP;
4. The recommended services identified in the assessment report, ISP, or ITDP;
5. The actual services to be provided, as described in the ISP, plan for interim services, or ITDP;
6. The access to or prompt provision of services provided under Title XIX;
7. The findings of the clinical team with regard to the client's competency, capacity to make decisions, need for guardianship or other protective services, or need for special assistance;
8. The review, modification, or termination of an ISP, ITDP, or portion thereof;
9. The application of the procedures and timetables as set forth in this Article for developing the ISP or ITDP;
10. The implementation of the ISP or ITDP;
11. The decision to provide service planning, including the provision of assessment or case management services, to a client who is refusing such services, or a decision not to provide such services to such an client; or
12. Decisions regarding a client's fee assessment or the denial of a request for a waiver thereof.

D. Initiation of the appeal.
1. An appeal may be initiated by any of the following persons:
   a. The client or applicant requesting mental health services;
   b. The client's or applicant's guardian; or
   c. The client's or applicant's designated representative.
2. An appeal is initiated by notifying the director of the regional authority in writing of the decision, report, plan or action being appealed, including a brief statement of the reasons for the appeal and the current address and telephone number, if available, of the applicant or client and designated representative.
3. An appeal must be initiated within 35 days of the decision, report, plan, or action being appealed. However, the director of the regional authority shall accept a late appeal for good cause. If the regional authority director refuses to accept a late appeal, the director shall notify the individual or client in writing, with a statement of reasons for the decision. Within ten days of the notification, the client or applicant may request review of that decision by the deputy director of the division, who shall act within 15 days of receipt of the request for review. The decision of the deputy director shall be final.
4. Within five days of receipt of an appeal, the director of the regional authority shall inform the client in writing in English and Spanish that the appeal has been received and of the procedures which will be followed during the appeal.

E. Informal conference with the regional authority.
1. Within seven days of receipt of the notice of appeal, the director of the regional authority shall hold an informal conference with the client, any designated representative and/or guardian, the case manager and representatives of the clinical team, and a representative of the service provider, if appropriate.
   a. The regional authority director shall schedule the conference at a convenient time and place and shall inform all participants in writing of the time, date, and location two days prior to the conference.
   b. Individuals may participate in the conference by telephone.
2. The director of the regional authority shall chair the informal conference and shall seek to mediate and resolve the issues in dispute. To the extent that resolution satisfactory to the client or guardian is not achieved, the regional authority director shall clarify issues for further appeal and shall determine the agreement, if any, of the participants as to the material facts of the case.
3. Except to the extent that statements of the participants are reduced to an agreed statement of facts, all statements made during the informal conference shall be considered as offers in compromise and shall be inadmissible in any subsequent hearing or court proceedings under this rule.
4. If the informal conference with the director of the regional authority does not resolve the issues in dispute to the satisfaction of the client or guardian, the client or guardian shall be informed that the matter will be further appealed to the Division, and of the procedure for requesting waiver of the informal conference with the Division.
5. If resolution satisfactory to the client or guardian is achieved, the director of the regional authority shall issue a dated written notice to all parties which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved and the date by which the resolution will be implemented.

F. Informal conference with the Division.
1. Within three days of the conclusion of an informal conference with the regional authority, the director of the regional authority shall notify the deputy director of the Division if the informal conference failed to resolve the appeal and shall immediately forward the client's notice of appeal, all documents relevant to the resolution of the appeal and any agreed statements of fact.
2. Within 15 days of the notification from the regional authority director, the deputy director of the Division shall hold an informal conference with the client, any designated representative and/or guardian, the case manager, and representatives of the clinical team, the service provider, if appropriate, for the purpose of mediating and resolving the issues being appealed.
   a. The deputy director of the Division shall schedule the conference at a convenient time and place and shall inform the participants in writing of the time, date, and location five days prior to the conference.
   b. Individuals may participate in the conference by telephone.
   c. If a client is unrepresented at the conference but needs assistance, or if for any other reason the deputy director of the Division determines the appointment of a representative to be in the client's best interest, the deputy director may designate a human rights advocate or other person to assist the client in the appeal.
3. To the extent that resolution satisfactory to the client or guardian is not achieved, the deputy director shall clarify issues for further appeal and shall determine the agreement, if any, of the participants as to the material facts of the case.

4. If resolution satisfactory to the client or guardian is achieved, the deputy director shall issue a dated written notice to all parties which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved, and the date by which the resolution will be implemented.
5. Except to the extent that statements of the participants are reduced to an agreed statement of facts, all statements made during the informal conference shall be considered as offers in compromise and shall be inadmissible in any subsequent hearing or court proceedings under this rule.
6. The client or guardian may waive the informal conference with the Division. If the conference is waived or if all issues in dispute are not resolved to the satisfaction of the client or guardian at the conference with the Division, the appeal shall proceed to a fair hearing under the provisions of subsection (G).

G. The fair hearing.

1. Within three days of the informal conference with the Division, if the conference failed to resolve the appeal, or within five days of the date the conference was waived, the deputy director of the Division shall notify the director to schedule a fair hearing.
2. Within five days of the notification, the director shall send a written notice of fair hearing to all parties, informing them of the time and place of the hearing, the name, address, and telephone number of the hearing officer, and the issues to be resolved. The notice shall also be sent to the appropriate human rights committee and the Office of Human Rights if the client is in need of special assistance.
3. Not less than 20 nor more than 30 days from such notice, the Department shall hold a fair hearing on the appeal in a manner consistent with A.R.S. §§ 36-111 and 36-112, and 41-1061 et seq. (the Administrative Procedure Act), and those portions of R9-1-101 through R9-1-126 which are not inconsistent with this Article. The client or any designated representative and/or guardian may request that the hearing be scheduled in a shorter or longer time. The Department shall make reasonable efforts to accommodate such request.
4. During the pendency of the appeal, the client, any designated representative and/or guardian, the clinical team, and representatives of any service providers may agree to implement any part of the ISP or ITDP or other matter under appeal without prejudice to the appeal.
5. The hearing shall be conducted by an impartial hearing officer appointed by the Department. The hearing officer may not be an employee of the Department, a regional authority or of a service provider under contract or subcontract with the Department. The Department may contract with a qualified individual to serve as a hearing officer under this rule.
6. The client or applicant shall have the right to be represented at the hearing by a person chosen by the client or applicant at the client's or applicant's own expense, in accordance with Rule 31(a)(3), Rules of the Supreme Court.
7. The client, any designated representative and/or guardian, and the opposing party shall have the right to present any evidence relevant to the issues under appeal and to call and examine witnesses. The Division shall have the right to appear to present legal argument.
8. The client and any designated representative and/or guardian shall have the right to examine and copy at a reasonable time prior to the hearing all records held by the Department, regional authority, or service provider pertaining to the client and the issues under appeal, including all records upon which the ISP or ITDP decisions were based.
9. Any portion of the hearing may be closed to the public if the client requests or if the hearing officer determines that it is necessary to prevent the unwarranted invasion of a client's privacy or that public disclosure would pose a substantial risk of harm to a client.
10. Within five days of the conclusion of the hearing, the hearing officer shall prepare and send a written, proposed decision to the director of the Department, together with the appeal record. The proposed decision shall be based exclusively on the evidence introduced at the hearing, shall designate these issues which relate to Title XIX services, and shall include findings of fact, conclusions, and a recommendation for appropriate action.
11. Within 15 days of the conclusion of the hearing, the director shall render a final written decision, based upon the findings, conclusions, and recommendations of the hearing officer.
    a. The decision shall include a concise statement of the facts found, a summary of the evidence relied upon, the decision and the reasons for so deciding and a notice of the right to seek rehearing under R9-1-120 and judicial review under A.R.S. § 36-113.
    b. The decision shall also include a notice to the parties of their right to appeal to AHCCCSA for review of decisions related to Title XIX services.
    c. The decision shall be mailed by certified mail to the parties to the hearing, their designated representatives, and the Division.
    d. The Department shall arrange to have the director's decision explained to the client, together with the right to seek rehearing, judicial review, or appeal to AHCCCSA, in a manner that is understandable to the client or the client's designated representative.

H. Expedited appeal.

1. At the time an appeal is initiated, the applicant, client, or mental health agency may request in writing an expedited appeal on issues related to crisis or emergency services or for good cause. Any appeal from a decision denying admission to or continued stay at an inpatient psychiatric facility due to lack of medical necessity shall be accompanied by all medical information necessary to resolution of the appeal and shall be expedited.
2. An expedited appeal shall be conducted in accordance with the provisions of this rule, except as provided for in this subsection.
3. Within one day of receipt of an expedited appeal, the director of the regional authority shall inform the client in writing in English and Spanish that the appeal has been received.
4. The director of the regional authority shall accept an expedited appeal on issues related to crisis or emergency services. The regional director shall also accept an expedited appeal for good cause. If the regional authority director refuses to expedite the appeal based on a determination that good cause does not exist, the director shall notify the applicant or client in writing within one day of the initiation of the appeal, with a statement of reasons for the decision, and shall proceed with the appeal in accordance with the provisions of this rule. Within three days of the notification of refusal to expedite the appeal for good cause, the client or applicant may request review of the decision by the deputy director of

the Division, who shall act within one day. The decision of the deputy director shall be final.

5. If the regional director accepts the appeal for expedited consideration, the director shall hold the informal conference pursuant to R9-21-315(E) within two days of the initiation of the appeal. The regional director shall schedule the conference at a convenient time and place and shall inform all participants of the time, date and location prior to the conference.
6. Within one day of the conclusion of an informal conference with the regional authority, the director of the regional authority shall notify the deputy director of the Division if the informal conference failed to resolve the appeal and shall immediately forward the client's notice of appeal and any agreed statements of fact.
7. Within two days of the notification from the regional authority director, the deputy director of the Division shall hold the informal conference pursuant to R9-21-315(F)
8. Within one day of the informal conference with the Division, if the conference failed to resolve the appeal, or within two days of the date the conference was waived, the deputy director shall notify the director to schedule a fair hearing.
9. Within one day of notification, the director shall send a written notice of fair hearing in accordance with R9-21-315(G)(2).
10. Within five days of such notice, the Department shall hold a fair hearing on the appeal in accordance with R9-21-315(G)(3).
11. Within one day of the conclusion of the hearing, the hearing officer shall prepare and send a written, proposed decision to the director of the Department in accordance with R9-21-315(G)(10).
12. Within two days of the conclusion of the hearing, the director shall render a final written decision in accordance with R9-21-315(G)(11). The decision of the director is the final decision of the Department on all issues and there shall be no right to a rehearing before the director.

I. Appeal of Title XIX services.

1. Within 15 days of the decision of the director, the client may appeal the decisions relating to Title XIX services to AHCCCSA by filing a written notice of appeal with the Department. The client may request a de novo hearing or a record review with oral argument before AHCCCSA.
2. An appeal to AHCCCSA does not preclude a client or individual from also seeking rehearing and judicial review pursuant to R9-21-315(J) where appropriate.

J. Rehearing or review of decision. A client or applicant aggrieved by the director's decision on issues not related to Title XIX services must file for rehearing within 15 days of service of the decision. The decision of the director on rehearing is the final decision of the Department on all decisions not related to Title XIX services.

K. Judicial review. A client or applicant aggrieved by a final decision of the Department may, within 35 days of receipt of the decision of the director after a rehearing, seek judicial review, in accordance with the standards and procedures contained in A.R.S. §§ 12-901 et seq.

L. Standard and burden of proof.

1. The standard of proof on all issues shall be by a preponderance of the evidence.
2. The burden of proof on the issue of the need for or appropriateness of mental health services shall be on the person appealing.
3. The burden of proof on the issue of the sufficiency of the assessment and further evaluation, and the need for guardianship, conservatorship, or special assistance shall be on the agency which made the decision.
4. The burden of proof on issues relating to services or placements shall be on the party advocating the more restrictive alternative.

M. Implementation of final decision. Within five days after a satisfactory resolution is achieved at an informal conference or after the expiration of an appeal period when no appeal is taken, or after the exhaustion of all appeals and subject to the final decision thereon, the director shall implement the final decision and shall notify the client, any designated representative and/or guardian, and Division of such action.

N. Appeal log.

1. The Department shall maintain a public log of all appeals filed under this rule. The director of the regional authority shall forward to the Department all information necessary for the accurate and timely maintenance of the public log.
2. The public log shall not include personally identifiable information but shall be a public record, available for inspection and copying by any person.
3. With respect to each entry, the Department's public logs shall contain:
   a. A unique docket number assigned by the Department;
   b. A substantive but concise description of the appeal including whether the appeal related to the provision of Title XIX services;
   c. The date of the filing of appeal;
   d. The date of the initial decision appealed from;
   e. The date, nature and outcome of all subsequent decisions, appeals, or other relevant events; and
   f. A substantive but concise description of the final decision and the action taken by the agency director and deputy director of the Division and the date the action was taken.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

ARTICLE 4. GRIEVANCE AND INVESTIGATION PROCEDURE FOR PERSONS WITH SERIOUS MENTAL ILLNESS

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-401. Scope

A. It is the policy of the Division to conduct investigations and bring matters to a resolution in four circumstances: first, in the event of a death of a client; second, whenever there is alleged to have occurred a rights violation; third, whenever there is alleged to exist a condition requiring investigation because it is

dangerous, illegal or inhumane; and fourth, in any other case where an investigation would be in the public interest, as determined by the director of the Department or the deputy director of the Division. The purpose of this Article is to implement that policy. All investigations pursuant to this Article shall be carried out in a prompt and equitable manner and with due regard for the dignity and rights of all persons involved. This Article does not obviate the need for systematically reporting, where appropriate, accidents and injuries involving clients.

B. This grievance and investigation procedure applies to any allegation that a rights violation or a condition requiring investigation, as defined in R9-21-101, has occurred or currently exists.

1. A grievance may be filed by a client, guardian, human rights advocate, human rights committee, State Protection and Advocacy System, designated representative, or any other concerned person when a violation of the client's rights or of the rights of several clients has occurred.
2. A request for an investigation may be filed by any person whenever a condition requiring investigation occurs or has occurred.
3. Allegations about the need for or appropriateness of mental health services should generally not be considered a grievance under this Article but instead should be addressed pursuant to the Individual Service Planning rules, R9-21-301 et seq., where applicable.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

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R9-21-402. Initiating a Grievance or Investigation

A. Any person may make an oral or written grievance or request for investigation to the director or any employee of a mental health agency who shall, if the grievance or request contains a non-frivolous allegation that there has occurred a rights violation or condition requiring investigation, forward the grievance to the appropriate person as set forth in R9-21-403. If asked to do so by a client, an employee shall assist the client in making an oral or written grievance or shall direct the client to the available supervisory or managerial staff who shall assist the client in making an oral or written grievance.

B. Any employee of a service provider, regional authority, inpatient facility, or the Division who has reason to believe that a rights violation or condition requiring investigation has occurred shall forthwith file a grievance or a request for investigation. Failure of an employee to file a grievance or request for investigation, to assist a client in filing a grievance, or to otherwise fail to forward a grievance submitted by a client shall be grounds for appropriate disciplinary action.

C. The director of a service provider, the director of a regional authority, or the deputy director of the Division shall initiate a grievance under this Article whenever there is a non-frivolous allegation that there has occurred a rights violation in an agency or program.

D. The director of a service provider, the director of a regional authority, or the deputy director of the Division shall initiate an investigation under this rule whenever there is a non-frivolous allegation or whenever there is reason to believe that there exists or has occurred a condition requiring investigation in an agency or program.

E. The director of the Department or the deputy director of the Division may initiate an investigation under this rule whenever the director or deputy director determines that an investigation would be in the best interests of the client, the Department, or the public.

F. Any grievance or request for investigation shall be accurately and completely reduced to writing on a grievance or request for investigation form provided by the Department.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

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R9-21-403. Persons Responsible for Resolving Grievances and Requests for Investigation

A. Rights violations.

1. Allegations involving rights violations other than physical or sexual abuse which occurred in an agency which is operated by, or as a result of an action of a person employed by, a mental health agency, except a mental health agency operated by a governmental entity, shall be addressed to and initially decided by the director of the appropriate regional authority.
2. Allegations involving rights violations other than physical or sexual abuse which occurred in an agency operated exclusively by, or as a result of an action of a person employed by, a governmental entity shall be addressed to and initially decided by the director of the agency.
3. Allegations involving physical or sexual abuse which occurred in an agency which is operated by, or as a result of an action of a person employed by, a mental health agency shall be addressed to the deputy director of the Division and shall be decided by the deputy director.

B. Conditions requiring investigation.

1. Allegations involving conditions requiring investigation other than a client death which occurred in an agency which is operated by, or as a result of an action of a person employed by, a mental health agency shall be addressed to and initially decided by the director of the appropriate regional authority.
2. Allegations involving conditions requiring investigation other than a client death which occurred in an agency operated exclusively by, or as a result of an action of a person employed by, a governmental entity shall be addressed to and initially decided by the director of the agency.
3. Allegations involving a client death which occurred in an agency which is operated by, or as a result of an action of a person employed by, a mental health agency shall be

addressed to the deputy director of the Division and shall be decided by the deputy director.

C. Notice of receipt of grievance or request for investigation.

1. Within five days of receipt of a grievance or request for investigation, the director of the agency shall inform the person filing the grievance or request in writing that the grievance or request has been received.
2. Within five days of receipt of a grievance or request for investigation, the director of an agency operated exclusively by a governmental entity shall provide a copy of the grievance or request to the appropriate regional authority.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-404. Preliminary Disposition

A. Summary disposition.

1. The agency director or deputy director of the Division may summarily dispose of any grievance or a request for an investigation where the alleged rights violation or condition occurred more than one year immediately prior to the date on which the grievance or request is made.
2. An agency director or deputy director of the Division who receives a grievance or request which is primarily directed to the level or type of mental health treatment provided to a client, which can be fairly and efficiently addressed within the procedures set forth in Article 3, and which do not directly or indirectly involve any rights set forth in A.R.S. Title 36 or Article 2, may refer the grievance to the case manager for resolution through the Individual Service Plan process.

B. Disposition without investigation.

1. Within five days of receipt of a grievance or request for an investigation, an agency director or deputy director of the Division may promptly resolve a grievance or request without conducting a full investigation, where the matter:
   a. Involves no dispute as to the facts;
   b. Is patently frivolous; or
   c. May be resolved fairly and efficiently within five days without a formal investigation.
2. Within five days of receipt of the grievance or request, the agency director or deputy director of the Division shall prepare a written, dated decision.
   a. The decision shall explain the essential facts, why the agency director or deputy director believes that the matter may be appropriately resolved without the appointment of an investigator, and the resolution of the matter.
   b. The agency director or deputy director of the Division shall send copies of the decision to the parties, together with a notice of appeal rights, and to anyone else having a direct interest in the matter.
3. After the expiration of the appeal period without appeal by any party, or after the exhaustion of all appeals and subject to the final decision thereof, the agency director or deputy director shall promptly take appropriate action and prepare and add to the case record a written, dated report of the action taken to resolve the grievance or request.

C. Matters requiring investigation.

1. If the matter complained of cannot be resolved without a formal investigation pursuant to the criteria set forth in subsection (B)(l), within five days of receipt of the grievance or request the agency director or deputy director shall prepare a written, dated appointment of an impartial investigator who, in the judgment of the agency director or deputy director, is capable of proceeding with the investigation in an objective manner but who shall not be:
   a. Any of the persons directly involved in the rights violation or condition requiring investigation; or
   b. A staff person who works in the same administrative unit as, except a person with direct line authority over, any person alleged to have been involved in the rights violation or condition requiring investigation.
2. Immediately upon the appointment of an investigator, the agency director or deputy director shall notify the person filing the grievance or request for investigation in writing of the appointment. The notice shall contain the name of the investigator, the procedure by which the investigation will be conducted and the method by which the person may obtain assistance or representation.

D. However the matter is initially resolved, where the client is in need of special assistance, as defined in R9-21-101, the agency director or deputy director shall immediately send a copy of the grievance or request and appointment to the Office of Human Rights and the committee with jurisdiction over the agency.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-21-405. Conduct of Investigation

A. Within ten days of the appointment, the investigator shall hold a private, face-to-face conference with the person who filed the grievance or request for investigation to learn the relevant facts which form the grounds for the grievance or request, except where the grievance or request has been initiated by the agency director or deputy director of the Division pursuant to R9-21-402(C) - (E).

1. In scheduling such conference, and again at the conference, if the client appears without a designated representative, the investigator shall advise the client that:

a. The client may be represented by a designated representative of the client's own choice. The investigator shall also advise the client of the availability of assistance from the State Protection and Advocacy System, the Office of Human Rights, and the relevant human rights committee.
b. The client may tape record the conference and all future conferences, meetings or hearings to which the client may be a party during the investigation, provided that the client notify all other parties not later than the beginning of the meeting or hearing that the client intends to do so.
c. In any case where the person initiating the grievance or request, or the person(s) who is alleged to have been responsible for the rights violation or condition, is a client and is in need of special assistance and is unrepresented, the investigator shall give the Office of Human Rights notice of the need for representation.

2. Where the grievance has been initiated by the agency director or deputy director of the Division, the investigator shall promptly determine which persons have relevant information concerning the occurrence of the alleged rights violation or condition requiring investigation and proceed to interview such individuals.

B. Within 15 days of the appointment, but only after the conference with the person initiating the grievance or request for investigation, the investigator shall hold a private, face-to-face conference with the person(s) complained of or thought to be responsible for the rights violation or condition requiring investigation to discuss the matter.

1. In scheduling the conference with such person(s) or with any other witness, the investigator shall advise the person(s) or any other witness that:
a. The individual may tape-record the conference and all future conferences, meetings or hearings during the course of the investigation, provided that the individual must notify all other parties to such meetings or hearings not later than the beginning of the meeting or hearing if the individual intends to so record.
b. An employee of an inpatient facility, service provider, regional authority or the Division has an obligation to cooperate in the investigation.
c. Failure of an employee to cooperate may result in appropriate disciplinary action.

C. The investigator shall gather whatever further information may seem relevant and appropriate, including interviewing additional witnesses, requesting and reviewing documents, and examining other evidence or locations.

D. Within ten days of completing all interviews with the parties but not later than 30 days from the date of the appointment, the investigator shall prepare a written, dated report briefly describing the investigation and containing findings of fact, conclusions, and recommendations. The report shall be delivered to the agency director or deputy director of the Division within the 30-day period.

E. Within five days of receiving the investigator's report, the agency director or deputy director of the Division shall review the report and the case record and prepare a written, dated decision which shall either:

1. Accept the investigator's report in whole or in part, at least with respect to the facts as found, and state a summary of findings and conclusions and the intended action of the agency director or deputy director, including disciplinary action against the person(s) responsible for the rights violation or condition requiring investigation, if appropriate.
a. The agency director or deputy director shall send copies of the decision to the investigator, the parties, the Office of Human Rights, and the human rights committee for persons deemed in need of special assistance.
b. The decision sent to the grievant and the client who is the subject of the grievance shall include a notice of appeal rights.

2. Reject the report for insufficiency of facts and return the matter for further investigation. In such event, the investigator shall complete the further investigation and deliver a revised report to the agency director or deputy director of the Division or designee within ten days. Upon receipt of the report, the agency director or deputy director shall proceed as provided in subsection (E)(l).

F. After the expiration of the appeal period set forth in R9-21-406, or after the exhaustion of all appeals and subject to the final decision thereof, the agency director or deputy director of the Division shall promptly take the action set forth in the decision and add to the case record a written, dated report of the action taken. A copy of the report shall be sent to the Office of Human Rights and the human rights committee if the client is in need of special assistance.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-21-406. Administrative Appeal

A. Any grievant or the client who is the subject of the grievance who is dissatisfied with the final decision of the agency director may, within 30 days of receipt of the decision, file a notice of appeal with the deputy director of the Division. The appealing party shall send copies of the notice to the other parties and their representatives and to the agency director, who shall forward the full case record to the deputy director of the Division.

B. The deputy director of the Division shall review the notice of appeal and the case record, and may discuss the matter with any of the persons involved or convene an informal conference. Within 15 days of the filing of the appeal, the deputy director of the Division shall prepare a written, dated decision which shall either:

1. Accept the investigator's report, in whole or in part, at least with respect to the facts as found, and affirm, modify or reject the decision of the agency director with a statement of reasons; or
2. Reject the investigator's report for insufficiency of facts and return the matter with instructions to the agency director for further investigation and decision. In such event, the further investigation shall be completed and a

revised report and decision shall be delivered to the deputy director of the Division within ten days. Upon receipt of the report and decision, the deputy director of the Division shall render a final decision, consistent with the procedures set forth in subsection (B)(1).

3. A designated representative shall be afforded the opportunity to be present at any meeting or conference convened by the deputy director of the Division to which the represented party is invited.
4. The deputy director of the Division shall send copies of the decision to:
   a. The parties, together with a notice of appeal rights;
   b. The agency director; and
   c. The Office of Human Rights and the human rights committee for clients who are in need of special assistance.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-21-407. Further Appeal to Administrative Hearing

A. Any grievant or the client who is the subject of the grievance who is dissatisfied with the decision of the deputy director of the Division may request a fair hearing before an administrative hearing officer.
1. Within 30 days of the date of the decision, the appealing party shall file with director of the Department a notice requesting a fair hearing.
2. Upon receipt of the notice, the director shall send a copy to the parties, to the deputy director of the Division, and to the Office of Human Rights and the human rights committee for clients who are in need of special assistance.
3. Within five days of the receipt of the notice of further appeal, the director of the Department shall appoint an impartial hearing officer. The hearing officer may not be an employee of the Department, a regional authority, or of a service provider under contract or subcontract with the Department. However, the Department may contract with a qualified individual to serve as the hearing officer under this rule. The director shall send copies of the appointment to the hearing officer together with the case record and to the parties including the Division.
4. Within five days of the appointment, the hearing officer shall inform the parties, the Office of Human Rights, and the human rights committee if the client is in need of special assistance, of the time and place of the hearing. The hearing shall be scheduled not less than 20 nor more than 30 days from the receipt of the request for fair hearing at a location convenient to all parties.

B. The hearing shall be conducted consistent with A.R.S. §§ 36-111 and 36-112 and 41-1061 et seq. (the Administrative Procedure Act), and those portions of R9-1-101 through R9-1-126 which are consistent with this Article.
1. The client shall have the right to be represented at the hearing by an individual chosen by the client at the client's own expense, in accordance with Rule 31(a)(3), Rules of the Supreme Court.
   a. If the client has not designated a representative to assist the client at the hearing and is in need of special assistance, the human rights committee, through one of its members or the human rights advocate unless refused by the client, shall make all reasonable efforts to represent the client.
   b. If the client is unrepresented and the deputy director of the Division determines the appointment of a representative to be in the client's best interest, the deputy director shall designate a representative to assist the client in the appeal.
2. The client or other appealing party shall have the right to present any evidence relevant to the issues under appeal and shall have the right to call and examine witnesses.
3. The client or other party appealing on behalf of the client shall have the right to examine all records held by the Department pertaining to the client.
4. Any portion of the hearing may be closed to the public if the client requests or if the hearing officer determines that it is necessary to prevent an unwarranted invasion of the client's privacy or that public disclosure would pose a substantial risk of harm to the client.
5. The standard of proof on all issues shall be a preponderance of the evidence.
6. The burden of proof on all issues shall be on the appealing party.
7. Within ten days of the conclusion of the hearing, the hearing officer shall prepare, date, sign, and send a written recommended decision to director of the Department, together with the case record. The recommended decision shall include findings of fact, which shall be binding on the Department for administrative purposes, and conclusions and recommendations for action as appropriate.

C. Within 20 days of the conclusion of the hearing, the director of the Department shall render a final written decision, based upon the recommendation of the hearing officer.
1. The decision shall include a concise statement of the facts found, a summary of the evidence relied upon, the decision and the reasons for so deciding, and a notice of the client's right to petition the director of the Department for a rehearing under R9-1-113 and to seek judicial review under A.R.S. § 36-113.
2. The decision shall be mailed promptly to the client, the other parties, and their designated representatives.
3. The Division shall arrange to have the decision explained to the client, together with the right to seek rehearing and judicial review.
4. Except to the extent that the decision is subject to an order for rehearing, the decision of the director is the final decision of the Department on all issues.

D. Within 15 days of the date of service of the decision of the director, the client or party appealing on behalf of the client may petition the director for a rehearing or review pursuant to R9-1-120.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under

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R9-21-408. Judicial Review

A client aggrieved by a final decision of the Department may, within 30 days of receipt of a decision after a rehearing, seek judicial review of the decision, in accordance with the standards and procedures contained in A.R.S. § 12-901 et seq.

Historical Note

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R9-21-409. Notice and Records

A. Notice to clients. All clients shall be informed of their right to file a grievance or request for investigation under these rules.
1. Notice of this grievance and investigation process shall be included in the information posted or otherwise provided to every current and new client and employee. Special efforts shall be made to inform current and new residents of mental health facilities of this process and of the right to file a grievance or request for investigation;
2. A copy of a brief memorandum explaining these rules shall be given to every current and new resident of a inpatient facility;
3. Such memorandum and blank copies of the forms for filing a grievance, request for investigation, and appeal shall be posted in a prominent place in plain sight on every unit of an inpatient facility or in a program operated by a service provider; and
4. Such memoranda, forms and copies of these rules shall be available at each inpatient facility, regional authority and service provider upon request by any person at any time.

B. Notice and oversight by the Office of Human Rights and human rights committees.
1. Upon receipt of any grievance or request for investigation involving a client who is in need of special assistance, the agency director or deputy director of the Division shall immediately forward a copy of such grievance or request to the Office of Human Rights and the appropriate regional human rights committee.
2. Upon receipt of such a grievance from the agency director or the deputy director of the Division, at the request of a client, or on its own initiative, the Office of Human Rights and/or the appropriate human rights committee shall assist a client in filing a grievance or request, if necessary. The Office and/or committee shall use its best efforts to see that such client is represented by an attorney, human rights advocate, committee member, or other person to protect the individual's interests and present information on the client's behalf. The Office and/or committee shall maintain a list of attorneys and other representatives, including the state protection and advocacy system, available to assist clients.
3. Whenever the human rights committee has reason to believe that a rights violation involving abuse or a dangerous condition requiring investigation, including a client death, has occurred or currently exists, or that any rights violation or condition requiring investigation occurred or exists which involves a client who is in need of special assistance, it may, upon written notice to the official before whom the matter is pending, become a party to the grievance or request. As a party it shall receive copies of all reports, plans, appeals, notices and other significant documents relevant to the resolution of the grievance or request and be able to appeal any finding or decision.
4. The Office of Human Rights shall assist clients in resolving grievances pursuant to R9-21-105.

C. Notification of other persons.
1. Whenever any rule, regulation, statute, or other law requires notification of a law enforcement officer, public official, medical examiner, or other person that an incident involving the death, abuse, neglect, or threat to a client has occurred, or that there exists a dangerous condition or event, such notice shall be given as required by law.
2. An agency director shall immediately notify the deputy director of the Division when:
   a. A client brings criminal charges against an employee;
   b. An employee brings criminal charges against a client;
   c. An employee or client is indicted or convicted because of any action required to be investigated by this Article; or
   d. A client of an inpatient facility, mental health agency, or service provider dies. The agency director shall report such death pursuant to the Department's policy on the reporting and investigation of deaths.
   e. A client of an inpatient facility, agency, or service provider allegedly is physically or sexually abused.
3. The investigation by the Department provided for by this Article is independent of any investigation conducted by police, the county attorney, or other authority.

D. Case records.
1. A file, known as the case record, shall be kept for each grievance or request for investigation which is received by the Division including ASH, regional authority or service provider under contract or subcontract with the Department. The record shall include the grievance or request, the docket number assigned by the Department, the names of all persons interviewed and the dates of those interviews, either a taped or written summary of those interviews, a summary of documents reviewed, copies of memoranda generated by the investigation, the investigator's report, the agency director's decision, and all documents relating to any appeal.
2. The investigator shall maintain possession of the case record until the investigation report is submitted. Thereafter, the agency director shall maintain control over the case record, except when the matter is on appeal.

During any appeal, the record will be in the custody of the official hearing or deciding the appeal.

E. Public logs.

1. The Department shall maintain a public log of all deaths and non-frivolous grievances or requests for investigation for all inpatient facilities, agencies, and service providers which it operates, funds, or supervises. The agency director of each facility or mental health agency shall forward to the Department all information necessary for the accurate and timely maintenance of the public log.
2. The public log shall not include personal identities but shall be a public record, available for inspection and copying by any person.
3. With respect to each grievance or request for investigation, the Department's public log shall contain:
   a. A docket number, consisting of a symbol for the agency, the last two digits of the year and a serial number assigned by the Department;
   b. A substantive but concise description of the grievance or request for investigation;
   c. The date of the filing of grievance;
   d. The date of the initial decision or appointment of investigator;
   e. The date of the filing of the investigator's final report;
   f. A substantive but concise description of the investigator's final report;
   g. The dates of all subsequent decisions, appeals, or other relevant events; and
   h. A substantive but concise description of the final decision and the action taken by the agency director or deputy director of the Division.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-21-410. Miscellaneous

A. Client protection. The agency director or any other official before whom a grievance or request for investigation is pending shall immediately take whatever action may be reasonable to protect the health, safety and security of any client, complainant or witness.

B. Disqualification of official. The agency director, deputy director of the Division, investigator, or any other official with authority to act on a grievance or request for investigation shall disqualify themselves from acting, if such official cannot act on the matter impartially and objectively, in fact or in appearance. In the event of such disqualification, the official shall forthwith prepare and forward a written, dated memorandum explaining the reasons for the decision to the deputy director of the Division or designee or director of the Department or designee, as appropriate, who shall, within ten days of receipt thereof, take such steps as are necessary to resolve the grievance in an impartial, objective manner.

C. Request for extension of time.

1. The investigator or any other official of a mental health agency acting pursuant to this Article may secure an extension of any time limit provided in this Article with the permission of the director of the regional authority.
2. The investigator or any other official of an inpatient facility acting pursuant to this Article may secure an extension of any time limit provided in this Article with the permission of the deputy director of the Division.
3. The investigator or any other official of the office of the deputy director of the Division acting pursuant to this Article may secure an extension of any time limit provided in this Article with the permission of the director of the Department.
4. An extension of time may only be granted upon a showing of necessity and a showing that the delay will not pose a threat to the safety or security of the client.
5. A request for such extension shall be in writing, with copies to all parties. The request shall explain why an extension is needed and propose a new time limit which does not unreasonably postpone a final resolution of the matter.
6. Such request shall be submitted to and acted upon by the director of the regional authority, deputy director of the Division, or director of the Department, as appropriate, prior to the expiration of the original time limit. Failure of the relevant official to act within the time allowed shall constitute a denial of the request for an extension.

D. Procedural irregularities.

1. Any party may protest the failure or refusal of any official with responsibility to take action in accord with the procedural requirements of this Article, including the time limits, by filing with the deputy director of the Division a written protest. A protest concerning the failure or refusal to take action by the deputy director of the Division or designee should be filed with the director of the Department.
2. Within ten days of the filing of such a protest, the official with whom it is filed shall take appropriate action to insure that if there is or was a violation of a procedure or timeline, it is promptly corrected, including, if appropriate, disciplinary action against the official responsible for the violation or by removal of an investigator or hearing officer and the appointment of a substitute.

E. Deputy director's or director's investigation.

1. The deputy director of the Division or director of the Department may at any time order that a special investigator review and report directly to the director or deputy director as to the facts of a grievance or condition requiring investigation, including a death or other matter.
2. The special investigator, deputy director and director shall comply with the time limits and other procedures for an investigation set forth in this Article.
3. Any final decision issued by the deputy director of the Division or the director of the Department based on such an investigation under this rule is appealable as provided in R9-21-407 et seq.
4. Nothing in this Article shall prevent the Department or the Division from conducting an investigation independent of these rules.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective

October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

ARTICLE 5. COURT-ORDERED EVALUATION AND TREATMENT

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-501. Responsibilities of Regional Authority

A. The regional authority shall perform, either directly or by contract, all pre-petition screening, evaluation and treatment, required by A.R.S. Title 36, Chapter 5, Articles 4 and 5, and this Article. In order to perform these functions, the regional authority or its contractor must be licensed by the Department.

B. A mental health agency may provide court-ordered treatment pursuant to A.R.S. Title 36, Chapter 5, Article 5, other than through contract with the regional authority, provided that:

1. The mental health agency is licensed by the Department to provide the court-ordered treatment;
2. The mental health agency complies with all applicable requirements under A.R.S. Title 36, Chapter 5, Article 5; and
3. The individual ordered to undergo treatment is not a client of the regional authority.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

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R9-21-502. Court-ordered Evaluation

A. An application for court-ordered evaluation shall be made to the appropriate regional authority on Department form MH-100, Titled "Application for Involuntary Evaluation", set forth in Exhibit A.

B. If authorized under A.R.S. § 36-521, the regional authority shall prepare and file with the court a petition for court-ordered evaluation on Department form MH-105, titled "Petition for Court-ordered Evaluation", set forth in Exhibit B. With respect to clients, the regional authority shall prepare a petition for court-ordered evaluation (form MH-105) in consultation with the client's clinical team.

C. Any mental health agency or service provider, which is not a regional authority under R9-21-501, that receives an application for court-ordered evaluation shall immediately refer the applicant to the appropriate regional authority for pre-petition screening and petitioning for court-ordered evaluation as provided under A.R.S. Title 36, Chapter 5, Article 4.

D. Whenever possible, the regional authority shall conduct pre-petition screening.

E. The regional authority shall recommend to the court that court-ordered evaluations be conducted on an outpatient basis whenever possible and when consistent with the medical needs of the individual.

Historical Note

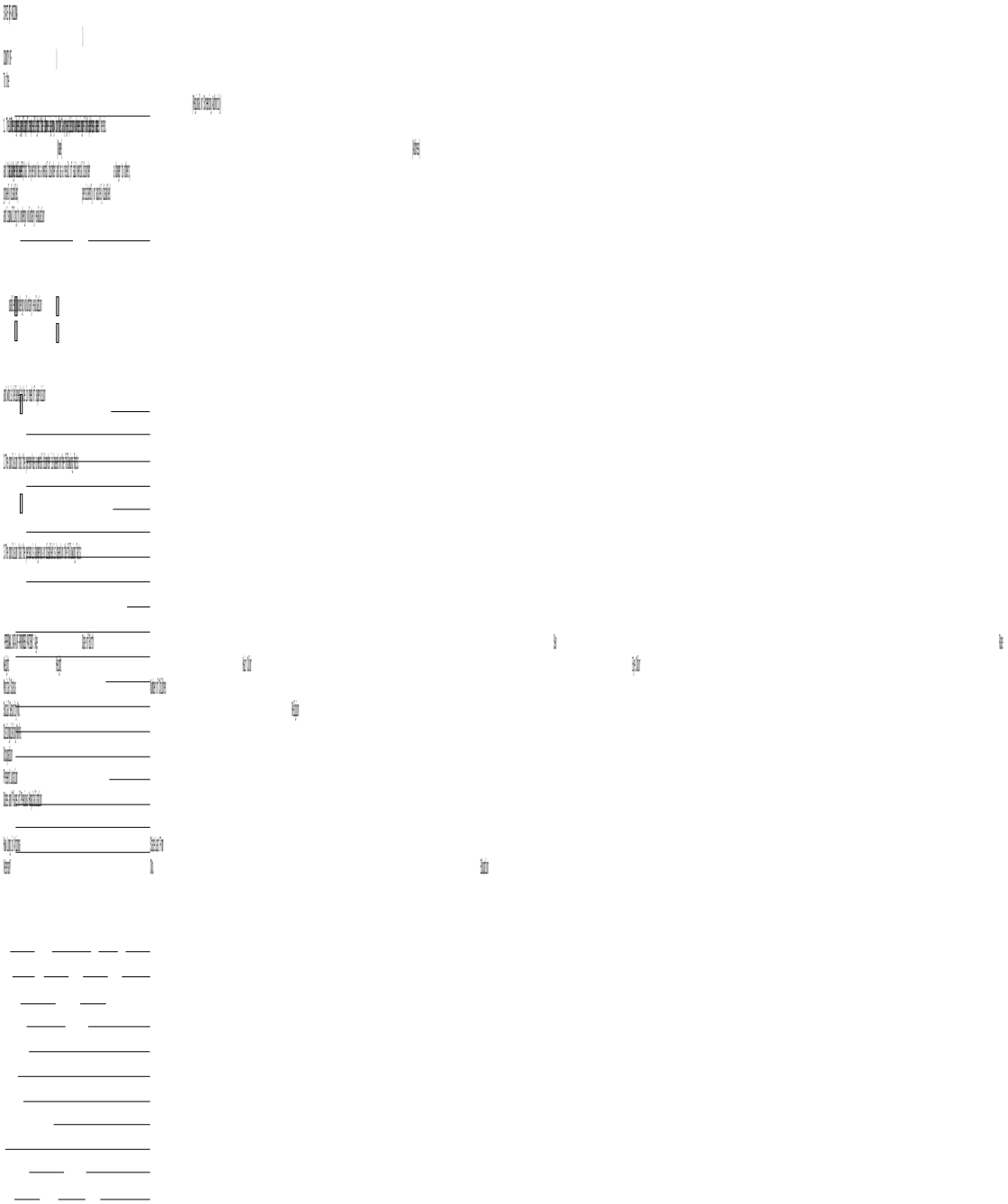
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

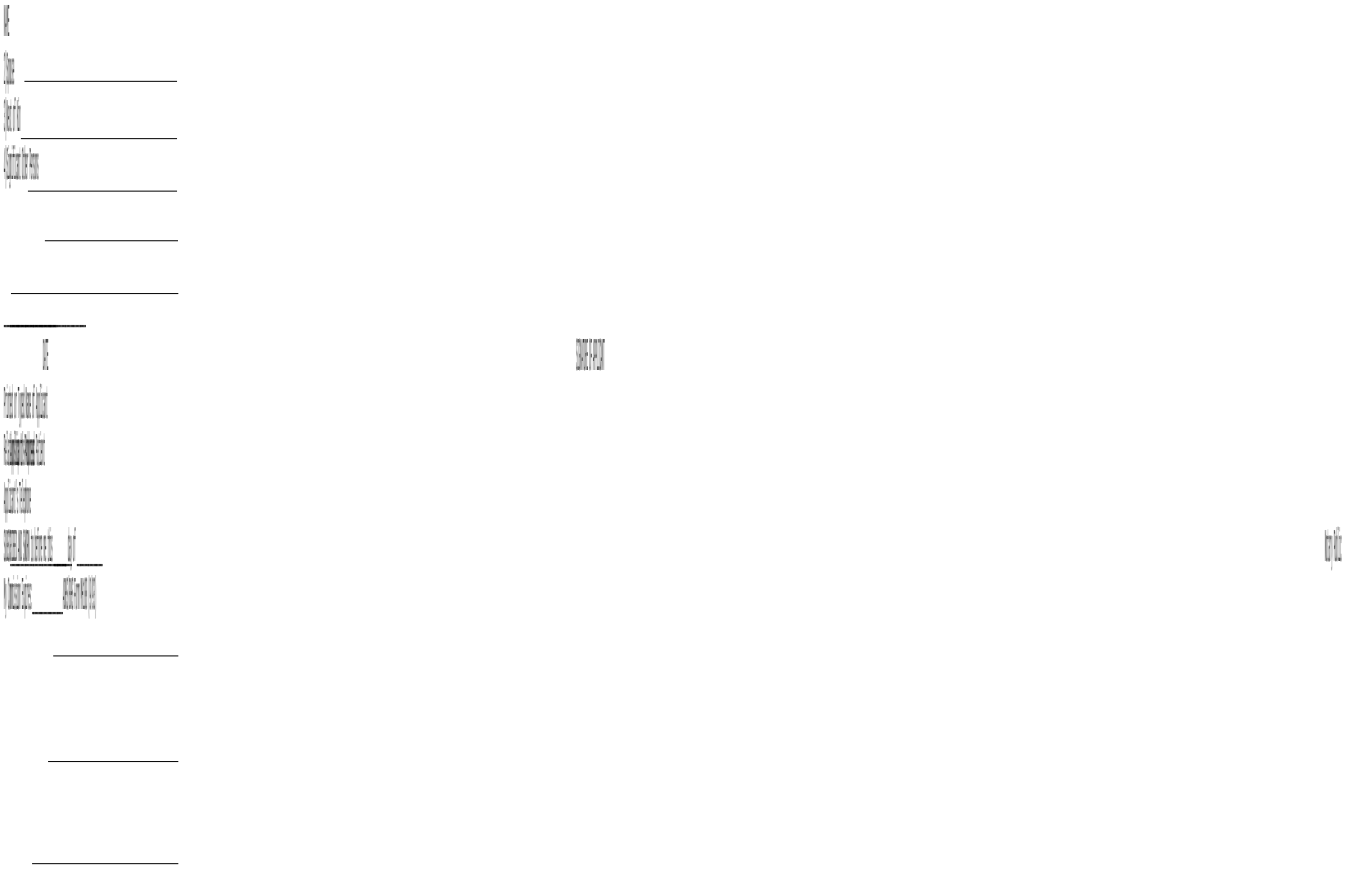
Editor's Note: The following Exhibit was adopted, repealed, and a new Exhibit adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

EXHIBIT A **(Pursuant to A.R.S. § 36-520)**

APPLICATION FOR INVOLUNTARY EVALUATION

Historical Note





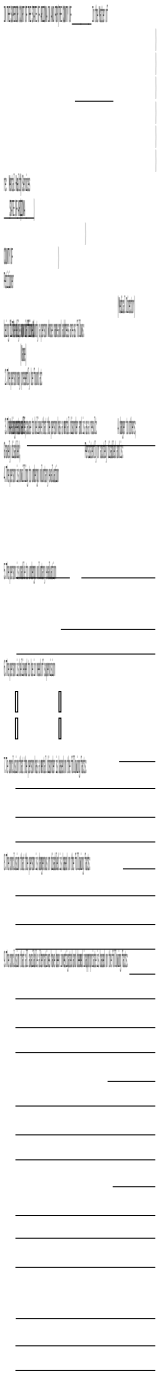
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit A repealed, new Exhibit A adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Exhibit was adopted, repealed, and a new Exhibit adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

EXHIBIT B

PETITION FOR COURT-ORDERED EVALUATION

Historical Note



Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit B repealed, new Exhibit B adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-503. Emergency Admission for Evaluation

A. An application for emergency evaluation pursuant to A.R.S. § 36-524 may be made to any evaluation agency licensed and approved by the Department to provide such services on Department form MH-104, Titled "Application for Emergency Admission for Evaluation", set forth in Exhibit C.

B. Prior to admission of an individual under this rule, the evaluation agency shall notify the appropriate regional authority of the potential admission so that the regional authority may first:
1. Provide services or treatment to the individual as an alternative to admission; or
2. Authorize admission of the individual.

C. If the evaluation agency does not provide notice pursuant to subsection (B) of this rule, the regional authority shall not be obligated to pay for the services provided.

D. Only a mental health agency licensed and approved by the Department to accept emergency admissions pursuant to A.R.S. §§ 36-524 and 36-526 may provide court-ordered emergency admission services under Title 36, Chapter 5, Article 4.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

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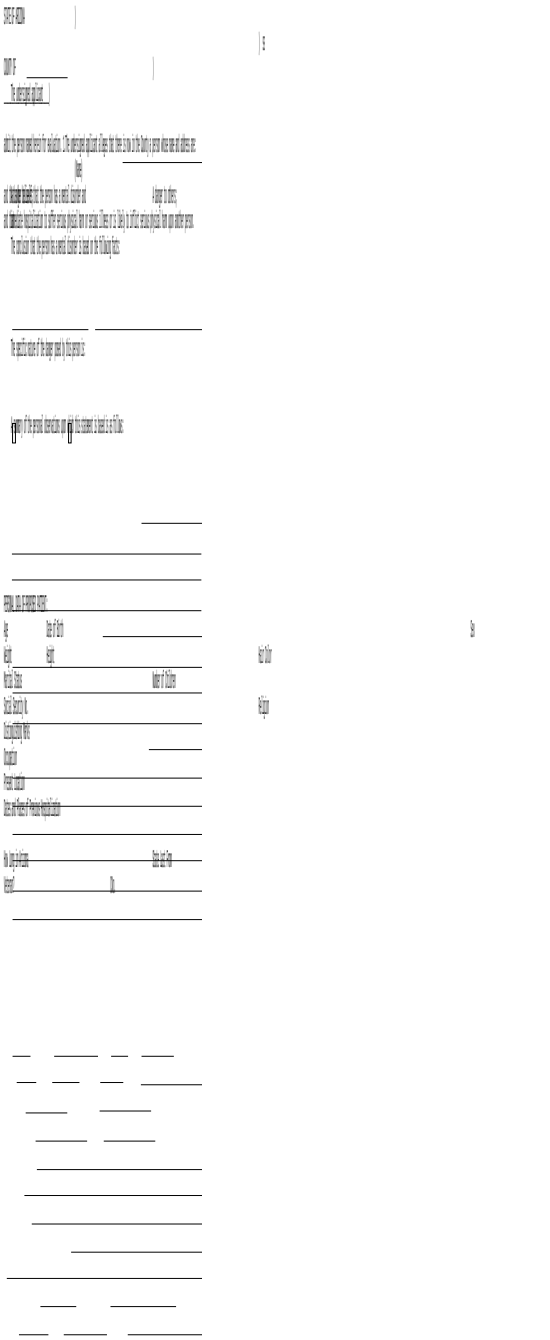
EXHIBIT C

APPLICATION FOR EMERGENCY ADMISSION FOR EVALUATION

(Pursuant to A.R.S. § 36-524)

Historical Note



Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit C repealed, new Exhibit C adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-504. Voluntary Admission for Evaluation

A. An application for voluntary evaluation pursuant to A.R.S. § 36-522 shall be made to the appropriate regional authority on Department form MH-103, Titled "Application for Voluntary Evaluation", set forth in Exhibit D.

B. The regional authority shall provide for such evaluation under A.R.S. § 36-522 for any individual who:
1. Voluntarily makes application as provided in subsection (A);
2. Gives informed consent; and
3. Has not been adjudicated as an incapacitated person pursuant to A.R.S. Title 14, Chapter 5, or Title 36, Chapter 5.

C. Any mental health agency, which is not a regional authority under R9-21-501, that receives an application for voluntary evaluation shall immediately refer the individual to the appropri ate regional authority for evaluation as provided under this rule, except as permitted by R9-21-503.

D. Any mental health agency providing voluntary evaluation services pursuant to this Article shall place in the medical record of the individual to be evaluated the following:
1. A completed copy of the application for voluntary treat ment;
2. A completed informed consent form pursuant to R9-21-511; and
3. A written statement of the individual's present mental condition.

E. Voluntary evaluation shall proceed only after the individual to be evaluated has given written consent on Department form MH-103 and received information that the patient-physician privilege does not apply and that the evaluation may result in a petition for the individual to undergo court-ordered treatment or for guardianship in the method prescribed by A.R.S. § 36-522.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

Editor's Note: The following Exhibit was adopted, repealed, and a new Exhibit adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

EXHIBIT D

APPLICATION FOR VOLUNTARY EVALUATION

(Pursuant to A.R.S. § 36-522)

The undersigned hereby requests a mental health evaluation to be performed by psychiatrists, psychologists, and social workers at

_____

_____

__

(Regional Authority)

on the following terms:

☐ INPATIENT. I agree to remain as an inpatient in the above agency for a period of not more than 72 hours. I understand that, at the end of that period, the agency must release me or file a Petition for Court-Ordered Treatment, in which case I may be held until the court holds a hearing, which shall be no longer than six days from the date of filing the petition, excluding weekends and holidays. If such a Petition is filed, I will have the right to representation by a lawyer, and the court will appoint one for me if I cannot afford one.

☐ OUTPATIENT. I agree to keep all scheduled appointments required for a complete evaluation, to the best of my ability. I understand that if I fail to appear, a Petition for Court-Ordered Evaluation or Treatment may be filed, in which case I may be detained and required to undergo involuntary evaluation and treatment. If such a Petition is filed, I will have the right to representation by a lawyer, and the court will appoint one for me if I cannot afford one.

_____I understand that the physician-patient privilege does not apply, and information I give during this evaluation may be used in court in a civil hearing for court-ordered treatment.

_____I understand that this evaluation may lead to a court hearing to determine if I need further treatment and that such treatment,or an investigation into the need for a guardianship, may be ordered by a court.

_____I understand that an application for my examination has been filed and I choose to be evaluated voluntarily rather than by court order.

_____I understand that my evaluation must take place within five days of my application.

_____I understand that I have a right to require the person who has applied for my evaluation to present evidence of the need for such evaluation to a court of law for approval or disapproval and I waive my right to require prior court review of the application.

_____I understand that I have a right, upon written request, to be discharged within 24 hours of that request (excluding weekends and holidays) unless the medical director of the evaluation agency files a petition for court-ordered evaluation.

_____

_____

_

Presented By

Signature of Applicant

_____

_

Printed or Typed Name of Applicant

_____

_

Date

ADHS/BHS Form MH-103 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit D repealed, new Exhibit D adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-505. Court-ordered Treatment

A. Upon a determination that an individual is a danger to self or others, gravely disabled, or persistently or acutely disabled, and if no alternatives to court-ordered treatment exist, the medical director of the agency that provided the court-ordered evaluation shall file the appropriate affidavits on Department form MH-112, set forth in Exhibit E, with the court, together with one of the following petitions:

1. A petition for court-ordered treatment for an individual alleged to be gravely disabled, which shall be filed on Department form MH-110, set forth in Exhibit F.
2. A petition for court-ordered treatment for an individual alleged to be a danger to self or others, which shall be filed on Department form MH-110, set forth in Exhibit F.
3. A petition for court-ordered treatment for an individual alleged to be persistently or acutely disabled, which shall be filed on Department form MH-110, set forth in Exhibit F.

B. Any mental health agency filing a petition for court-ordered treatment of a client pursuant to subsection (A) above shall do so in consultation with the client's clinical team prior to filing the petition.

C. with respect to inpatient and outpatient treatment, the petition filed with the court shall request that the individual be committed to the care and supervision of the regional authority, if the individual is a client, or to an appropriate mental health treatment agency, if the individual is not a client.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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EXHIBIT E

AFFIDAVIT

STATE OF ARIZONA)

) ss

COUNTY OF)

1. That affiant [illegible] is experienced in psychiatric matters; and studied information about said person;

2. That affiant finds the person to be suffering from a mental disorder diagnosed as

(Probable Diagnosis)

and is

(DSM Code)

A danger to self A danger to others

Gravely disabled Persistently or acutely disabled

4. The conclusion [illegible] mental disorder is based on the following facts:

[ ] [ ]

[ ] [ ]

B. Mental Status:

Emotional Process:

Thought:

Inquisition:

Memory:

5. The conclusion that the person is dangerous or disabled is based on the following:

6. The conclusion that all available alternatives have been investigated and deemed inappropriate is based on the following:

SUBSCRIBED AND SWORN to before me this ___ day of _____

My Commission Expires:

ADDRESS FROM WHICH (OR)

Physician's Signature

Notary Public

PERSISTENTLY OR ACUTELY DISABLED (EXHIBIT E, ADDENDUM NO. 1)

RE:

_____

_____

_____

IF PERSISTENTLY OR ACUTELY DISABLED:

1.Does the person have a severe mental disorder that, if not treated, has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional, or physical harm that significantly impairs judgment, reason, behavior, or capacity to recognize reality?

Yes _____ No _____

If yes, provide the facts that support this conclusion:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

2.Does the severe mental disorder substantially impair the person's capacity to make an informed decision regarding treatment?

Yes _____No _____

If yes, provide the facts that support this conclusion:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

2a.Does this impairment cause the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment, and understanding and expressing an understanding of the alternatives to the particular treatment offered?

Yes _____No _____

If yes, provide the facts that support this conclusion:

_____

_____

_____

_____

_____

_____

_____

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_____

_____

2b.Were the advantages and disadvantages of accepting treatment explained to the person?

Yes _____ No _____

2c.Were the alternatives to treatment and the advantages and disadvantages of such alternatives explained to the person?

Yes _____ No _____

2d.Explain the specific reasons why the person is incapable of understanding and expressing an understanding of the explanations described in 2a, 2b, and 2c:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

3.Is there a reasonable prospect that the severe mental disorder is treatable by outpatient, inpatient, or combined inpatient and outpatient treatment?

Yes _____ No _____

If yes, please provide the facts that support this conclusion:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ ADHS/BHS Form MH-112 Addendum No. 1 (9/93)

GRAVELY DISABLED (EXHIBIT E, ADDENDUM NO. 2)

RE:

_____

_____

_____

IF GRAVELY DISABLED:

1.Is the person's condition evidenced by behavior in which s/he, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because s/he would be unable to provide for his/her basic physical needs without hospitalization?

Yes _____ No _____

2.If Yes, explain how his/her mental disability affects his/her ability to do the following and how any inability might harm him/her. Provide examples, if available, to support your conclusion:

_____

_____

_____

_____

_____

_____

_____

_____

a.Provide for food:

_____

_____

_____

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b.Provide for clothing and maintain hygiene:

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c.Provide for shelter:

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_____

d.Obtain and maintain steady employment:

_____

_____

_____

_____

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_____

e.Respond in an emergency:

_____

_____

_____

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_____

f.Care for present or future medical problems:

_____

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g.Manage money:

_____

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_____

_____

_____

h.Other:

_____

_____

_____

_____

_____

_____ _____
_____ ADHS/BHS Form MH-112 Addendum No. 2 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit E repealed, new Exhibit E with Addenda 1 and 2 adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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EXHIBIT F

PETITION FOR COURT-ORDERED TREATMENT

Gravely Disabled Person

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit F repealed, new Exhibit F adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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R9-21-506. Coordination of Court-ordered Treatment Plans with ISPs and ITDPs

A. All inpatient and outpatient treatment plans prepared for clients pursuant to A.R.S. § § 36-533, 36-540 and 36-540.01, and any modifications thereto, shall be developed and implemented pursuant to the individual service planning procedures set forth in Article 3 of this Chapter, including the right of the client to request different services and to appeal such plan.

B. If a client's ISP or ITDP is inconsistent with an inpatient or outpatient treatment plan ordered by the court, the mental health agency or regional authority, whichever is appropriate, shall recommend to the court that the court-ordered plan be amended so that it is consistent with the client's ISP or ITDP.

C. If, during the period a client is on outpatient status, an emergency occurs that satisfies the standards for emergency admission under A.R.S. §§ 36-524 and 36-526, and that requires immedi ate revocation or modification of an outpatient order, a modification may be submitted to the court in consultation with the client's clinical team without complying with the individual service planning procedures, provided that the client and clinical team subsequently review

any such modification pursuant to the individual service planning procedures set forth in Article 3 of this Chapter.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

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R9-21-507. Review of Court-ordered Individual

A. The mental health treatment agency that provides care for an individual ordered by a court to undergo treatment shall:
1. Assure that an examination and review of a court-ordered individual is accomplished in an effective and timely fashion, but not less than 30 days prior to expiration of any treatment portion of the order.
2. Require written documentation of the examination and review.
3. Maintain a special record that shall include:
   a. The expiration date of any treatment portion of the court-ordered treatment; and
   b. The date by which the review and examination must be initiated.
4. Establish specific dates by which the review and examina tion will be accomplished.
5. Conduct the review and examination by the specified dates.

B. In addition to subsection (A), the examination and review process for court-ordered clients shall, at a minimum, include the following:
1. The client's clinical team shall hold an ISP meeting pursuant to R9-21-307, not less than 30 days prior to the expiration of any treatment portion of the court order, which shall include the treatment team of the treatment agency providing mental health services under the court order. The ISP meeting shall include a determination by the clinical team of:
   a. Whether the client continues to be a danger to others, a danger to self, gravely disabled, or persistently or acutely disabled;
   b. That no alternatives to court-ordered treatment are appropriate; and
   c. Whether court-ordered treatment should continue.
2. If, upon conclusion of the ISP meeting, the clinical team determines that the client:
   a. Continues to be a danger to others, a danger to self, gravely disabled, or persistently or acutely disabled;
   b. That no alternatives to court-ordered treatment are appropriate; and
   c. That court-ordered treatment should continue, the medical director of the mental health treatment agency providing care for the client committed by court order shall appoint two physicians (one of whom must be a psychiatrist) and the mental health worker assigned to the case to conduct an examination to determine whether the client continues to be a danger to others, a danger to self, gravely disabled, or persistently or acutely disabled.
3. After such examination, the examining physicians shall enter a note in the progress sheet of the medical record stating the findings, decision, and the basis for that decision.
4. If the medical finding is that the client continues to be a danger to self, a danger to others, gravely disabled, or persistently or acutely disabled, and if no alternatives to court-ordered treatment exist, the mental health treatment agency shall file a petition and affidavit(s) as provided in R9-21-505.

C. In addition to subsection (A), the examination and review process for non-clients shall, at a minimum, include the following:
1. A person designated by the mental health agency providing treatment shall notify the medical director of the agency in writing of the expiration date 30 days prior to expiration of the court-ordered treatment.
2. The medical director shall within five days notify one or more physicians (at least one of whom must be a psychiatrist) and the mental health worker assigned to the case of the expiration date of the court-ordered treatment and appoint them to determine whether the non-client continues to be a danger to others, a danger to self, gravely disabled, or persistently or acutely disabled.
3. After such examination, the examining physician(s) shall enter a note in the progress sheet of the medical record stating the findings, decision, and the basis for that decision.
4. If the medical finding is that the non-client continues to be a danger to self, a danger to others, gravely disabled, or persistently or acutely disabled, and if no alternatives to court-ordered treatment exist, the mental health treatment agency shall file a petition and affidavits as provided in R9-21-505.

Historical Note

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R9-21-508. Transfer of Gravely Disabled Persons

A. An individual found by the court to be gravely disabled and without a guardian may be transferred from a mental health treatment agency to another agency, provided that the medical director of the mental health treatment agency initiating the transfer has established that:
1. There is no reason to believe the individual will suffer more serious physical harm or serious illness as a result of the transfer; and

   2.The individual is being transferred to a level and kind of treatment more appropriate to the individual's treatment needs.

B.The medical director of the agency initiating the transfer

must:

1. Be the medical director of the agency to which the court committed the individual; or

2. Obtain the court's consent to the transfer as necessary.

C. All clients shall be transferred pursuant to the procedures set forth in Article 3 of this Chapter. With regard to non-clients, the medical director of the agency initiating the transfer may not transfer a non-client to, or use the services of, any other agency, unless the medical director of the other agency has agreed to provide such services to a non-client to be transferred, and the Department has licensed and approved that agency to provide those services.

D. The medical director of the mental health treatment agency initiating the transfer shall notify the receiving agency in sufficient time for the intended transfer to be accomplished in an orderly fashion, but not less than three days. This notification shall include:

1. A summary of the individual's needs.
2. A statement that, in the medical director's judgment, the receiving agency can adequately meet the individual's needs.
3. If the individual is a client, a modification of a client's ISP pursuant to R9-21-314, when applicable.
4. Documentation of the court's consent, when applicable.

E. The medical director of the transferring agency must present a written compilation of the individual's clinical needs and suggestions for future care to the medical director of the receiving agency, who must accept and approve it before an individual can be transferred pursuant to subsection (A) above.

F. The transportation of individuals transferred from one agency to another shall be the responsibility of the agency initiating the transfer, irrespective of the allocation of the cost of the transportation defined elsewhere.

Historical Note

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R9-21-509. Requests for Notification

A. At any time during a specified period of court-ordered treatment in which an individual has been found to be a danger to others, a relative or victim wishing to be notified in the event of a individual being released prior to the expiration of the period of court-ordered treatment shall file a demand, pursuant to A.R.S. § 36-541.01(D), on Department form MH-127 set forth in Exhibit G.

B. At any time during a specified period of court-ordered treatment in which an individual has been found to be a danger to others, a person other than a relative or victim wishing to be notified in the event of an individual being released prior to the expiration of the period of court-ordered treatment shall file a petition and form of order, pursuant to A.R.S. § 36-541.01(D) on Depart ment form MH-128 set forth in Exhibit H.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

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EXHIBIT G

DEMAND FOR NOTICE BY RELATIVE OR VICTIM

(Pursuant to A.R.S. § 36-541.01)

REGARDING:

_____

_____

(Full Name of Patient)

Pursuant to A.R.S. § 36-541.01, with respect to the above-named patient, a person who was ordered to undergo treatment for a mental disorder as a danger to others pursuant to A.R.S. § 36-540 by a court order of the Superior Court of _____ County, Case Number _____, or who was committed by an Arizona tribal court, which order of commitment was duly domesticated pursuant to A.R.S. §§ 12-1702 et seq., the undersigned _____ relative _____victim does hereby demand that the medical director of

_____

_____ , the mental health treatment agency providing court-ordered treatment for said person, provide the undersigned with written notice of intention to release or discharge said person prior to the expiration of the period for treatment ordered by the Court, as provided for in A.R.S. § 36-541.01(D).

The undersigned person demanding notice hereby agrees to advise the treatment agency in writing, by certified mail, return receipt requested, of any change in the address to which notice is to be mailed.

_____

Signature of Applicant

_____	_____
_	_
Printed or Typed Name of Applicant	Address to Mail Notice
_____	_____
_	_
Date	Telephone Number of Applicant

ADHS/BHS Form MH-127 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit G repealed and a new Exhibit G adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Exhibit was adopted, repealed, and a new Exhibit adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules. (Exhibit H was formerly located following Section R9-21-505.)

EXHIBIT H

PETITION FOR NOTICE

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA

IN AND FOR THE COUNTY OF _____

In the matter of)
) MH
_____
)
) PETITION FOR NOTICE
)
) (Pursuant to A.R.S. § 36-541.01)
re: Mental Health Services)
)
_____)

REGARDING:

_____
_____

(Full Name of Patient)

Pursuant to A.R.S. § 36-541.01, with respect to the above-named patient, a person who was ordered to undergo treatment for a mental disorder as a danger to others pursuant to A.R.S. § 36-540 by a court order of the Superior Court of _____ County, Case Number _____, the undersigned, a person other than a relative or victim of the person hereby asserting a legitimate reason for receiving such notice, does hereby petition the Court to require that the medical director of _____, the mental health treatment agency providing court-ordered treatment for said person, provide the undersigned with written notice of intention to release or discharge said person prior to the expiration of the period for treatment ordered by the Court, as provided for in A.R.S. § 36-541.01, and does hereby provide the following information required by A.R.S. § 36-541.01(D):

Legitimate reason for receiving notice:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

The undersigned person demanding notice hereby agrees to advise the treatment agency in writing, by certified mail, return receipt requested, of any change in the address to which notice is to be mailed.

_____
_____

Signature of Person Petitioning

_____
_____

Printed or Typed Name of Petitioner

_____
_____

Date

_____
_____

Address to Send Notice

_____
_____

Telephone Number of Applicant

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA

IN AND FOR THE COUNTY OF

_____

In the Matter of)
) MH
)
) ORDER FOR NOTICE
)
)
re: Mental Health Services)
)
)
)

1.The Court having received a demand by

_____

, a relative or victim of _____

, a patient ordered by the Court to undergo treatment for a mental disorder as a danger to others, for written notice from the medical director of_____, the mental health treatment agency providing court-ordered treatment for said patient, of intention to release or discharge said patient prior to the expiration of the period ordered by the Court, as provided for in A.R.S. § 36-541.01, which demand included all information required by A.R.S. § 36-541.01(D);

2.The Court having received a petition by _____

, a person other than a relative or victim of _____

, a patient ordered by this Court to undergo treatment for a mental disorder as a danger to others, asserting that the petitioner has a legitimate reason for receiving such notice and petitioning the Court to require that the medical director of _____,

the mental health treatment agency providing court-ordered treatment for said patient, provide the petitioner with written notice of intention to release or discharge said patient prior to the expiration of the period for treatment ordered by the Court, as provided for in A.R.S. §36-541.01, which petition included all information required by A.R.S. § 36-541.01(D); and the Court, after considering said petition, having found that the petitioner has a legitimate reason for receiving prior notice.

THEREFORE IT IS ORDERED that the medical director of _____, a mental health treatment agency, shall not release or discharge the above-named patient from court-ordered inpatient treatment without first giving written notice of the intention to do so, in accordance with A.R.S. § 36-541.01(F), to:

____The above-named relative of the patient

____The above-named victim of the patient

____The above-named petitioner found by the Court to have a legitimate reason for receiving prior notice.

IT IS FURTHER ORDERED that a copy of this Order for Notice shall be delivered to the above-named mental health treatment agency and shall be filed with the patient's clinical record, and if the patient is transferred to another agency or institution, any orders for notice shall be transferred with the patient.

DATED this _____ day of _____, 19 _____

_____

_____

SUPERIOR COURT JUDGE/COMMISSIONER

ADHS/BHS Form MH-128 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit H repealed, new Exhibit H adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-510. Voluntary Admission for Treatment

A. Application for admission for voluntary treatment pursuant to A.R.S. § 36-518 shall be made to a mental health agency on Department form MH-210, Titled "Application for Voluntary Treatment", set forth in Exhibit I, by any individual who:
1. Voluntarily makes application as provided in subsection (A);
2. Gives informed consent;
3. Has not been adjudicated as an incapacitated person pursuant to A.R.S. Title 14, Chapter 5, or Title 36, Chapter 5; and
4. If a minor, is appropriately admitted pursuant to A.R.S.§ 36-518.

B. Any mental health agency that is not a regional authority under R9-21-501 and that receives an application for voluntary treatment by a client shall immediately refer the client to the appropriate regional authority for treatment as provided under this rule, except that in the case of an emergency, a mental health treatment agency licensed by the Department to provide treatment under A.R.S. § 36-518 may accept an application for voluntary treatment and admit the client for treatment as follows:
1. Prior to admission of a client under this rule, the agency shall notify the appropriate regional authority of the potential admission and treatment so that the regional authority may first:
   a. Provide other services or treatment to the client as an alternative; or
   b. Authorize treatment of the client.
2. If the agency does not provide notice pursuant to subsec tion (B)(1) above, the regional authority shall not be obligated to pay for the treatment provided.

C. Any mental health agency providing treatment pursuant to A.R.S. § 36-518 shall place in the medical record of the individual to be treated the following:
1. A completed copy of the application for voluntary treat ment;

2. A completed informed consent form pursuant to R9-21-511; and
3. A written statement of the individual's present mental condition.

D. If the client admitted under this rule does not have an ISP, the regional authority shall prepare one in accordance with Article 3 of this Chapter. If the client already has an ISP, the regional authority shall commence a review of the ISP as provided in R9-21-313 and, if necessary, take steps to modify the ISP in accordance with R9-21-314.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Exhibit was adopted, repealed, and a new Exhibit adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules. (Exhibit I was formerly located following Section R9-21-509.)

EXHIBIT I

APPLICATION FOR VOLUNTARY TREATMENT

(Pursuant to A.R.S. § 36-518)

I,

_____

_____, hereby request that the

(Person's Name)

_____

_____ place me in a program or agency for mental health treatment.

(Mental Health Agency)

I understand that my capacity to give informed consent to treatment will be determined before I am allowed to voluntarily consent to treatment. My informed consent to treatment will be given on a separate form.

Further, I am aware that I am entitled to:

1.Withdraw or modify my consent to treatment at any time.

2.Receive a booklet explaining my rights under Arizona law and assistance from a human rights advocate if I desire.

3.A fair explanation of the treatment I am to receive and the purposes of that treatment.

4.A description of any material and substantial risk reasonably to be expected as a result of the treatment.

5.An answer to my inquiries concerning treatment.

6.Revoke my consent to treatment at any time.

7.Discharge within 24 hours of my written request (excluding weekends and holidays) unless the medical director of the treatment agency files a petition for court-ordered treatment.

_____

_

Person's Signature

_____

_

Date

ADHS/BHS Form MH-210 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit I repealed, new Exhibit I adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Exhibit was adopted and repealed under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

EXHIBIT K. REPEALED

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-511. Informed Consent in Voluntary Application for Admission and Treatment

A. Prior to beginning any course of medication or other treatment for an individual who is subject to voluntary admission under A.R.S. §§ 36-518 and 36-522, a mental health agency shall obtain an informed consent to treatment and enter it in the medical record. For all clients, the informed consent shall be obtained pursuant to R9-21-206.

B. For clients, the mental health agency shall make reasonable inquiry into an individual's capacity to give informed consent, record these findings, and enter these findings in the client's ISP or record pursuant to Articles 2 and 3 of this Chapter. For non-clients, the agency shall adopt admission procedures that shall include the following:
1. The medical director or the medical director's designee shall make reasonable inquiry into an individual's capacity to give informed consent.
2. The medical director or the medical director's designee shall record his findings regarding the individual's capacity to give and of having given informed consent.
3. That the findings of the medical director or the medical director's designee shall be entered into the individual's record.

C. Consent to permit treatment may be revoked at any time by a reasonably clear statement in writing.
1. An individual shall receive assistance in writing the revocation as necessary.
2. If consent to permit treatment is revoked, treatment shall be promptly discontinued, provided that a course of treatment may be concluded or phased out where necessary to avoid the harmful effects of abrupt withdrawal.

D. An informed consent form shall be signed by the individual and shall state that the following information was presented to the individual:
1. A fair explanation of the treatments and their purposes.
2. A description of any material and substantive risk reason ably to be expected.
3. An offer to answer any inquiries concerning the treatments.
4. Notice that the individual is free to revoke consent to treatment; and
5. For clients, all information required by R9-21-206.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-512. Use of Psychotropic Medication

A. Psychotropic medications may only be ordered for individuals undergoing court-ordered evaluation pursuant to R9-21-204 or R9-21-207.

B. Psychotropic medications may not be ordered for and adminis tered to individuals undergoing court-ordered treatment, except as follows:
1. In an emergency involving the safety of the individual or another, as documented in the individual's medical record;
2. If the individual or guardian gives an informed consent to use the medication;
3. If provision for use of the medications shall be contained in the individual's treatment plan or ISP. At a minimum, the plan shall specify:
   a. A description of the circumstances under which the medication may be used.
   b. A description of the objectives that are expected to be achieved by use of the medication. This description must indicate how the individual's condition would be improved by using the medication and indicate what result would be expected if the medication were not used; or
4. Pursuant to R9-21-204 or R9-21-207.

C. The agency shall have the capability to detect drug side effects or toxic reactions that may result from the medications used.

D. The agency shall have written policies and procedures govern ing the use of psychotropic medication. These policies and procedures shall specify:
1. Protective measures that will ensure the individual's safety and promote the avoidance or mitigation of short and long-term deleterious effects on the individual.
2. Periodic individual care monitoring, i.e., evaluating and updating the treatment plan and reviewing problem areas such as failure of the individual to achieve treatment plan objectives.
3. Recordkeeping requirements.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-513. Seclusion and Restraint

Individuals undergoing court-ordered evaluation or court-ordered treatment may not be placed in seclusion or restraint except as permitted by Article 2 of this Chapter, and specifically R9-21-204.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

Editor's Note: The following Exhibit was adopted, repealed, and a new Exhibit adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the

Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

EXHIBIT A
APPLICATION FOR INVOLUNTARY EVALUATION
(Pursuant to A.R.S. § 36-520)

STATE OF ARIZONA)
)
COUNTY OF)

To the _____
(Regional or Screening Authority)

1. The undersigned applicant requests that the above agency conduct a pre-petition screening of the person named herein.
2. The undersigned applicant alleges that there is now in the County a person whose name and address are:

_____ _____
(Name) (Address)

and that s/he believes that the person has a mental disorder and as a result of said mental disorder, is:

☐ a danger to self; ☐ a danger to others;
☐ gravely disabled; ☐ persistently or acutely disabled

and is:

☐ unwilling to undergo voluntary evaluation, as evidenced by the following facts: _____
_____
_____
_____

☐ unable to undergo voluntary evaluation, as demonstrated by the following facts: _____
_____
_____
_____

and who is believed to be in need of supervision, care, and treatment because of the following facts:_____
_____
_____

2. The conclusion that the person has a mental disorder is based on the following facts: _____
_____
_____
_____

3. The conclusion that the person is dangerous or disabled is based on the following facts:_____
_____
_____

PERSONAL DATA OF PROPOSED PATIENT:

Age _____ Date of Birth _____Sex _____ Race_____
Weight_____ Height _____ Hair Color _____ Eye Color_____
Marital Status _____Number of Children _____
Social Security No._____Religion _____
Distinguishing Marks _____
Occupation _____
Present Location _____
Dates and Places of Previous Hospitalization_____
How Long in Arizona _____State Last From_____
Veteran? _____ C-No. _____ Education_____

NAME, ADDRESS AND TELEPHONE NUMBER OF:
1) Guardian _____
2) Spouse _____
3) Next of Kin _____
4) Significant Other Persons

_____ _____
DATE SIGNATURE OF APPLICANT

Printed or Typed Name of Applicant _____

Relationship to Proposed Patient _____

Applicant's Address _____

Applicant's Telephone _____

SUBSCRIBED AND SWORN to before me this _____ day of _____, 19 _____

_____
Notary Public

My Commission Expires:

_____

ADHS/BHS Form MH-100 (9/93)

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit A repealed, new Exhibit A adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Exhibit was adopted, repealed, and a new Exhibit adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

EXHIBIT B
PETITION FOR COURT-ORDERED EVALUATION

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA IN AND FOR THE COUNTY OF _____

In the Matter of	)	
	)	MH
	)	_____
	)	PETITION FOR COURT-
	)	ORDERED EVALUATION
	)	(Pursuant to A.R.S. § 36-523)
	)	
re: Mental Health Services)		
_____	)	
STATE OF ARIZONA	)	
	)	
COUNTY OF	)	

Petitioner, _____
(Medical Director)
being first duly sworn/affirmed, alleges that:

1. There is now in this County a person whose name and address are as follows:

_____ _____
(Name) (Address)

2. The person may presently be found at: _____
_____

3. There is reasonable cause to believe that the person has a mental disorder and is as a result:
☐ A danger to self; ☐ A danger to others;
☐ Gravely disabled; ☐ Persistently or acutely disabled and is:

4. The person is unwilling to undergo voluntary evaluation, as evidenced by the following facts: _____
_____
_____
_____

5. The person is unable to undergo voluntary evaluation, as demonstrated by the following reasons: _____
_____
_____
_____

6. The person is believed to be in need of supervision, care, and treatment because of the following facts: _____
_____
_____
_____

7. The conclusion that the person has a mental disorder is based on the following facts: _____
_____
_____

8. The conclusion that the person is dangerous or disabled is based on the following facts: _____
_____
_____

9. The conclusion that all available alternatives have been investigated and deemed inappropriate is based on the following facts:
_____
_____
_____

10. Applicant information: _____
    Name of Applicant:_____
    Address of Applicant:_____
    Realtionship to or Interest in the Proposed Patient: _____
    _____
11. In the opinion of the Petitioner, the person is _____ is not ____ in such a condition that, without immediate or continuing hospitalization, s/he is likely to suffer serious physical harm or inflict serious physical harm upon another person.
12. In the opinion of the Petitioner, evaluation should ____ should not ____ take place on an outpatient basis, based upon the following reasons:_____
    _____
    _____

PETITIONER REQUESTS THAT THE COURT:
Issue an Order requiring the person to be given an ____ Inpatient ____ Outpatient evaluation.

_____ _____
DATE Signature Of Petitioner

_____ _____
Printed or Typed Name

SUBSCRIBED AND SWORN to before me this _____ day of _____, 19 _____.

_____
Notary Public

My Commission Expires:

_____

ADHS/BHS Form MH-105 (9/93)

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit B repealed, new Exhibit B adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-503. Emergency Admission for Evaluation

A. An application for emergency evaluation pursuant to A.R.S. § 36-524 may be made to any evaluation agency licensed and approved by the Department to provide such services on Department form MH-104, Titled "Application for Emergency Admission for Evaluation", set forth in Exhibit C.

B. Prior to admission of an individual under this rule, the evaluation agency shall notify the appropriate regional authority of the potential admission so that the regional authority may first:
1. Provide services or treatment to the individual as an alternative to admission; or
2. Authorize admission of the individual.

C. If the evaluation agency does not provide notice pursuant to subsection (B) of this rule, the regional authority shall not be obligated to pay for the services provided.

D. Only a mental health agency licensed and approved by the Department to accept emergency admissions pursuant to A.R.S. §§ 36-524 and 36-526 may provide court-ordered emergency admission services under Title 36, Chapter 5, Article 4.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

Editor's Note: The following Exhibit was adopted, repealed, and a new Exhibit adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

EXHIBIT C
APPLICATION FOR EMERGENCY ADMISSION FOR EVALUATION

(Pursuant to A.R.S. § 36-524)

STATE OF ARIZONA)
) ss
COUNTY OF _____)
_____)

The undersigned applicant, being first duly sworn/affirmed, hereby requests that _____
(Evaluation Agency)
admit the person named herein for evaluation.

1. The undersigned applicant alleges that there is now in the County a person whose name and address are:

_____ _____
(Name) (Address)

and that s/he believes that the person has a mental disorder and, as a result of said mental disorder, is:

☐ A danger to self; ☐ A danger to others;

and that, during the time necessary to complete pre-petition screening under A.R.S. §§ 36-520 and 36-521, the person is likely without immediate hospitalization to suffer serious physical harm or serious illness or is likely to inflict serious physical harm upon another person.

The conclusion that the person has a mental disorder is based on the following facts: _____
_____
_____
_____

The specific nature of the danger posed by this person is: _____
_____
_____
_____

A summary of the personal observations upon which this statement is based is as follows: _____
_____
_____
_____
_____
_____
_____

PERSONAL DATA OF PROPOSED PATIENT:

Age _____ Date of Birth _____ Sex _____ Race _____
Weight _____ Height _____ Hair Color _____ Eye Color _____
Marital Status _____ Number of Children _____
Social Security No. _____ Religion _____
Distinguishing Marks _____
Occupation _____
Present Location _____
Dates and Places of Previous Hospitalization _____
How Long in Arizona _____ State Last From _____
Veteran? _____ C-No. _____ Education _____

NAME, ADDRESS AND TELEPHONE NUMBER OF:

1) Guardian _____

2) Spouse _____

3) Next of Kin _____

4) Significant Other Persons _____
_____

_____ _____
DATE SIGNATURE OF APPLICANT

Printed or Typed Name of Applicant _____

Relationship to Proposed Patient _____

Applicant's Address _____

Applicant's Telephone _____

SUBSCRIBED AND SWORN to before me this _____ day of _____, 19_____.

_____
Notary Public

My Commission Expires:

_____

ADHS/BHS Form MH-104 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit C repealed, new Exhibit C adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-504. Voluntary Admission for Evaluation

A. An application for voluntary evaluation pursuant to A.R.S. § 36-522 shall be made to the appropriate regional authority on Department form MH-103, Titled "Application for Voluntary Evaluation", set forth in Exhibit D.

B. The regional authority shall provide for such evaluation under A.R.S. § 36-522 for any individual who:
1. Voluntarily makes application as provided in subsection (A);
2. Gives informed consent; and
3. Has not been adjudicated as an incapacitated person pursuant to A.R.S. Title 14, Chapter 5, or Title 36, Chapter 5.

C. Any mental health agency, which is not a regional authority under R9-21-501, that receives an application for voluntary evaluation shall immediately refer the individual to the appropriate regional authority for evaluation as provided under this rule, except as permitted by R9-21-503.

D. Any mental health agency providing voluntary evaluation services pursuant to this Article shall place in the medical record of the individual to be evaluated the following:

1. A completed copy of the application for voluntary treatment;
2. A completed informed consent form pursuant to R9-21-511; and
3. A written statement of the individual's present mental condition.

E. Voluntary evaluation shall proceed only after the individual to be evaluated has given written consent on Department form MH-103 and received information that the patient-physician privilege does not apply and that the evaluation may result in a petition for the individual to undergo court-ordered treatment or for guardianship in the method prescribed by A.R.S. § 36-522.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

Editor's Note: The following Exhibit was adopted, repealed, and a new Exhibit adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

EXHIBIT D
APPLICATION FOR VOLUNTARY EVALUATION

(Pursuant to A.R.S. § 36-522)

The undersigned hereby requests a mental health evaluation to be performed by psychiatrists, psychologists, and social workers at

_____
(Regional Authority)

on the following terms:

☐ INPATIENT. I agree to remain as an inpatient in the above agency for a period of not more than 72 hours. I understand that, at the end of that period, the agency must release me or file a Petition for Court-Ordered Treatment, in which case I may be held until the court holds a hearing, which shall be no longer than six days from the date of filing the petition, excluding weekends and holidays. If such a Petition is filed, I will have the right to representation by a lawyer, and the court will appoint one for me if I cannot afford one.

☐ OUTPATIENT. I agree to keep all scheduled appointments required for a complete evaluation, to the best of my ability. I understand that if I fail to appear, a Petition for Court-Ordered Evaluation or Treatment may be filed, in which case I may be detained and required to undergo involuntary evaluation and treatment. If such a Petition is filed, I will have the right to representation by a lawyer, and the court will appoint one for me if I cannot afford one.

_____ I understand that the physician-patient privilege does not apply, and information I give during this evaluation may be used in court in a civil hearing for court-ordered treatment.

_____ I understand that this evaluation may lead to a court hearing to determine if I need further treatment and that such treatment,or an investigation into the need for a guardianship, may be ordered by a court.

_____ I understand that an application for my examination has been filed and I choose to be evaluated voluntarily rather than by court order.

_____ I understand that my evaluation must take place within five days of my application.

_____ I understand that I have a right to require the person who has applied for my evaluation to present evidence of the need for such evaluation to a court of law for approval or disapproval and I waive my right to require prior court review of the application.

_____ I understand that I have a right, upon written request, to be discharged within 24 hours of that request (excluding weekends and holidays) unless the medical director of the evaluation agency files a petition for court-ordered evaluation.

_____ _____
Presented By Signature of Applicant

_____
Printed or Typed Name of Applicant

_____
Date

ADHS/BHS Form MH-103 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit D repealed, new Exhibit D adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the

Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-505. Court-ordered Treatment

A. Upon a determination that an individual is a danger to self or others, gravely disabled, or persistently or acutely disabled, and if no alternatives to court-ordered treatment exist, the medical director of the agency that provided the court-ordered evaluation shall file the appropriate affidavits on Department form MH-112, set forth in Exhibit E, with the court, together with one of the following petitions:

1. A petition for court-ordered treatment for an individual alleged to be gravely disabled, which shall be filed on Department form MH-110, set forth in Exhibit F.
2. A petition for court-ordered treatment for an individual alleged to be a danger to self or others, which shall be filed on Department form MH-110, set forth in Exhibit F.
3. A petition for court-ordered treatment for an individual alleged to be persistently or acutely disabled, which shall be filed on Department form MH-110, set forth in Exhibit F.

B. Any mental health agency filing a petition for court-ordered treatment of a client pursuant to subsection (A) above shall do so in consultation with the client's clinical team prior to filing the petition.

C. with respect to inpatient and outpatient treatment, the petition filed with the court shall request that the individual be committed to the care and supervision of the regional authority, if the individual is a client, or to an appropriate mental health treatment agency, if the individual is not a client.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Exhibit was adopted, repealed, and a new Exhibit adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

EXHIBIT E
AFFIDAVIT

STATE OF ARIZONA)
) ss
COUNTY OF)
_____)

_____, being first duly sworn, deposes and says:

1. That affiant is a physician and is experienced in psychiatric matters;
2. That affiant has examined _____ and studied information about said person;
3. That affiant finds the person to be suffering from a mental disorder diagnosed as _____
(Probable Diagnosis)
_____ and is, as a result thereof,
(DSM Code)

☐ A danger to self ☐ A danger to others
☐ Gravely disabled ☐ Persistently or acutely disabled

4. The conclusion that the person has a mental disorder is based on the following facts:
   A. Psychiatric Examination _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   B. Mental Status:
   Emotional Process: _____
   _____
   _____
   Thought: _____
   _____
   _____
   Cognition:
   _____
   _____
   Memory: _____
   _____
   _____

5. The conclusion that the person is dangerous or disabled is based on the following: _____
_____
_____

6. The conclusion that all available alternatives have been investigated and deemed inappropriate is based on the following:
_____
_____
_____
_____

_____
Physician's Signature

SUBSCRIBED AND SWORN to before me this _____ day of _____, 19_____.

_____
Notary Public

My Commission Expires: _____

ADHS/BHS Form MH-112 (9/93)

PERSISTENTLY OR ACUTELY DISABLED (EXHIBIT E, ADDENDUM NO. 1)

RE:_____

IF PERSISTENTLY OR ACUTELY DISABLED:

1. Does the person have a severe mental disorder that, if not treated, has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional, or physical harm that significantly impairs judgment, reason, behavior, or capacity to recognize reality?
   Yes _____ No _____

If yes, provide the facts that support this conclusion:_____
_____
_____
_____

2. Does the severe mental disorder substantially impair the person's capacity to make an informed decision regarding treatment?
   Yes _____No _____

If yes, provide the facts that support this conclusion:_____
_____
_____
_____

2a. Does this impairment cause the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment, and understanding and expressing an understanding of the alternatives to the particular treatment offered?
   Yes _____No _____

If yes, provide the facts that support this conclusion:_____
_____
_____
_____

2b. Were the advantages and disadvantages of accepting treatment explained to the person?
   Yes _____ No _____

2c. Were the alternatives to treatment and the advantages and disadvantages of such alternatives explained to the person?
   Yes _____ No _____

2d.Explain the specific reasons why the person is incapable of understanding and expressing an understanding of the explanations described in 2a, 2b, and 2c:_____
_____
_____
_____

3. Is there a reasonable prospect that the severe mental disorder is treatable by outpatient, inpatient, or combined inpatient and outpatient treatment?
   Yes _____ No _____

If yes, please provide the facts that support this conclusion:_____
_____
_____
_____

ADHS/BHS Form MH-112 Addendum No. 1 (9/93)

GRAVELY DISABLED (EXHIBIT E, ADDENDUM NO. 2)

RE: _____

IF GRAVELY DISABLED:

1. Is the person's condition evidenced by behavior in which s/he, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because s/he would be unable to provide for his/her basic physical needs without hospitalization?
   Yes _____ No _____

2. If Yes, explain how his/her mental disability affects his/her ability to do the following and how any inability might harm him/her. Provide examples, if available, to support your conclusion:
   _____
   _____
   _____

a. Provide for food:_____
   _____
   _____

b. Provide for clothing and maintain hygiene: _____
   _____
   _____

c. Provide for shelter: _____
   _____
   _____

d. Obtain and maintain steady employment: _____
   _____
   _____

e. Respond in an emergency: _____
   _____
   _____

f. Care for present or future medical problems : _____
   _____
   _____

g. Manage money: _____
   _____
   _____

h. Other:
   _____
   _____

ADHS/BHS Form MH-112 Addendum No. 2 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit E repealed, new Exhibit E with Addenda 1 and 2 adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Exhibit was adopted, repealed, and a new Exhibit adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

EXHIBIT F
PETITION FOR COURT-ORDERED TREATMENT
Gravely Disabled Person

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA IN AND FOR THE COUNTY OF _____

In the Matter of	)	
	)	MH
	)	
	)	PETITION FOR COURT-
	)	ORDERED TREATMENT
	)	(Pursuant to A.R.S. § 36-533)
re: Mental Health Services	)	Danger to Self/Others or
	)	Persistently or Acutely Disabled or
_____	)	Gravely Disabled

STATE OF ARIZONA	)	
	)	ss
COUNTY OF_____	)	
_____	)	

Petitioner _____, being first duly sworn/affirmed, alleges that:
(Medical Director)

1. _____is, as a result of a mental disorder:
   - ☐ danger to self ☐ danger to others
   - ☐ persistently or acutely disabled
   - ☐ gravely disabled

   and in need of treatment.

2. The court-ordered treatment alternatives that are appropriate and available are:
   - ☐ outpatient treatment [A.R.S. § 36-540(A)(1)].
   - ☐ combined inpatient and outpatient treatment [A.R.S. § 36-540(A)(2)].
   - ☐ inpatient treatment [A.R.S. § 36-540(A)(3)] at .

3. The person is unwilling or is unable to accept treatment voluntarily.

4. A summary of the facts supporting the above allegations is in the attached reports of examining physicians.

5. The person is residing or present in this county, or is admitted to an institution pursuant to an order of a court of competent jurisdiction sitting in this county, or who was committed by an Arizona tribal court, which order of commitment was duly domesticated pursuant to A.R.S. § 12-1702 et seq.

6. The person is entitled to notice of hearing of the petition and may be found at_____
(location)
_____

7. Petitioner believes the person requires a:
_____Title 14 guardian; _____ Conservator; _____Title 36 guardian
and requests the Court to order an investigation and report to be made to the Court regarding this need. Said need exists because:_____
_____
_____
_____

8. Petitioner believes the proposed person needs the immediate services of a temporary _____ guardian _____ conservator and requests that the Court appoint the same because: _____
_____
_____

9. Petitioner believes that _____ address: _____, is the person's guardian/conservator, who should receive notice of any hearing.

10 .A copy of this Petition has been mailed to the Public Fiduciary of_____ County and (other gardian, if any)_____

PETITIONER requests that the Court:

1. Set a date for a hearing; and
2. After notice and hearing find that the person is suffering from a mental disorder the result of which renders him/her dangerous to self or others, persistently or acutely disabled, or gravely disabled and order a period of treatment, all as set forth in paragraphs (1) and (2) above.
3. Check if applicable;

☐ Order an independent investigation and report to the Court regarding the need for a Title 14 guardian or conservator or Title 36 guardian.

☐ Appoint the following-named person as temporary guardian and/or conservator of the person, who Petitioner believes to be a fit and proper person to serve in that capacity:

_____ _____

(Proposed Temporary Guardian/Conservator) (Relation to Patient)

_____

(Address of Proposed Temporary Guardian/Conservator)

☐ Impose the duties of a Title 36 guardian upon the person's A.R.S. Title 14 guardian who is _____

_____

_____ _____

DATE Signature of Petitioner
Medical Director

SUBSCRIBED AND SWORN to before me this _____ day of _____, 19_____.

_____

NORTARY PUBLIC OR DEPUTY CLERK OF THE SUPERIOR COURT

My Commission Expires:

_____

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit F repealed, new Exhibit F adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-506. Coordination of Court-ordered Treatment Plans with ISPs and ITDPs

A. All inpatient and outpatient treatment plans prepared for clients pursuant to A.R.S. § § 36-533, 36-540 and 36-540.01, and any modifications thereto, shall be developed and implemented pursuant to the individual service planning procedures set forth in Article 3 of this Chapter, including the right of the client to request different services and to appeal such plan.

B. If a client's ISP or ITDP is inconsistent with an inpatient or outpatient treatment plan ordered by the court, the mental health agency or regional authority, whichever is appropriate, shall recommend to the court that the court-ordered plan be amended so that it is consistent with the client's ISP or ITDP.

C. If, during the period a client is on outpatient status, an emergency occurs that satisfies the standards for emergency admission under A.R.S. §§ 36-524 and 36-526, and that requires immediate revocation or modification of an outpatient

order, a modification may be submitted to the court in consultation with the client's clinical team without complying with the individual service planning procedures, provided that the client and clinical team subsequently review any such modification pursuant to the individual service planning procedures set forth in Article 3 of this Chapter.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-507. Review of Court-ordered Individual

A. The mental health treatment agency that provides care for an individual ordered by a court to undergo treatment shall:
1. Assure that an examination and review of a court-ordered individual is accomplished in an effective and timely fashion, but not less than 30 days prior to expiration of any treatment portion of the order.
2. Require written documentation of the examination and review.
3. Maintain a special record that shall include:
   a. The expiration date of any treatment portion of the court-ordered treatment; and
   b. The date by which the review and examination must be initiated.
4. Establish specific dates by which the review and examination will be accomplished.
5. Conduct the review and examination by the specified dates.

B. In addition to subsection (A), the examination and review process for court-ordered clients shall, at a minimum, include the following:
1. The client's clinical team shall hold an ISP meeting pursuant to R9-21-307, not less than 30 days prior to the expiration of any treatment portion of the court order, which shall include the treatment team of the treatment agency providing mental health services under the court order. The ISP meeting shall include a determination by the clinical team of:
   a. Whether the client continues to be a danger to others, a danger to self, gravely disabled, or persistently or acutely disabled;
   b. That no alternatives to court-ordered treatment are appropriate; and
   c. Whether court-ordered treatment should continue.
2. If, upon conclusion of the ISP meeting, the clinical team determines that the client:
   a. Continues to be a danger to others, a danger to self, gravely disabled, or persistently or acutely disabled;
   b. That no alternatives to court-ordered treatment are appropriate; and
   c. That court-ordered treatment should continue, the medical director of the mental health treatment agency providing care for the client committed by court order shall appoint two physicians (one of whom must be a psychiatrist) and the mental health worker assigned to the case to conduct an examination to determine whether the client continues to be a danger to others, a danger to self, gravely disabled, or persistently or acutely disabled.
3. After such examination, the examining physicians shall enter a note in the progress sheet of the medical record stating the findings, decision, and the basis for that decision.
4. If the medical finding is that the client continues to be a danger to self, a danger to others, gravely disabled, or persistently or acutely disabled, and if no alternatives to court-ordered treatment exist, the mental health treatment agency shall file a petition and affidavit(s) as provided in R9-21-505.

C. In addition to subsection (A), the examination and review process for non-clients shall, at a minimum, include the following:
1. A person designated by the mental health agency providing treatment shall notify the medical director of the agency in writing of the expiration date 30 days prior to expiration of the court-ordered treatment.
2. The medical director shall within five days notify one or more physicians (at least one of whom must be a psychiatrist) and the mental health worker assigned to the case of the expiration date of the court-ordered treatment and appoint them to determine whether the non-client continues to be a danger to others, a danger to self, gravely disabled, or persistently or acutely disabled.
3. After such examination, the examining physician(s) shall enter a note in the progress sheet of the medical record stating the findings, decision, and the basis for that decision.
4. If the medical finding is that the non-client continues to be a danger to self, a danger to others, gravely disabled, or persistently or acutely disabled, and if no alternatives to court-ordered treatment exist, the mental health treatment agency shall file a petition and affidavits as provided in R9-21-505.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-508. Transfer of Gravely Disabled Persons

A. An individual found by the court to be gravely disabled and without a guardian may be transferred from a mental health treatment agency to another agency, provided that the medical director of the mental health treatment agency initiating the transfer has established that:
1. There is no reason to believe the individual will suffer more serious physical harm or serious illness as a result of the transfer; and
2. The individual is being transferred to a level and kind of treatment more appropriate to the individual's treatment needs.

B. The medical director of the agency initiating the transfer must:

1. Be the medical director of the agency to which the court committed the individual; or
2. Obtain the court's consent to the transfer as necessary.

C. All clients shall be transferred pursuant to the procedures set forth in Article 3 of this Chapter. With regard to non-clients, the medical director of the agency initiating the transfer may not transfer a non-client to, or use the services of, any other agency, unless the medical director of the other agency has agreed to provide such services to a non-client to be transferred, and the Department has licensed and approved that agency to provide those services.

D. The medical director of the mental health treatment agency initiating the transfer shall notify the receiving agency in sufficient time for the intended transfer to be accomplished in an orderly fashion, but not less than three days. This notification shall include:
1. A summary of the individual's needs.
2. A statement that, in the medical director's judgment, the receiving agency can adequately meet the individual's needs.
3. If the individual is a client, a modification of a client's ISP pursuant to R9-21-314, when applicable.
4. Documentation of the court's consent, when applicable.

E. The medical director of the transferring agency must present a written compilation of the individual's clinical needs and suggestions for future care to the medical director of the receiving agency, who must accept and approve it before an individual can be transferred pursuant to subsection (A) above.

F. The transportation of individuals transferred from one agency to another shall be the responsibility of the agency initiating the transfer, irrespective of the allocation of the cost of the transportation defined elsewhere.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-509. Requests for Notification

A. At any time during a specified period of court-ordered treatment in which an individual has been found to be a danger to others, a relative or victim wishing to be notified in the event of a individual being released prior to the expiration of the period of court-ordered treatment shall file a demand, pursuant to A.R.S. § 36-541.01(D), on Department form MH-127 set forth in Exhibit G.

B. At any time during a specified period of court-ordered treatment in which an individual has been found to be a danger to others, a person other than a relative or victim wishing to be notified in the event of an individual being released prior to the expiration of the period of court-ordered treatment shall file a petition and form of order, pursuant to A.R.S. § 36-541.01(D) on Department form MH-128 set forth in Exhibit H.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Exhibit was adopted, repealed, and a new Exhibit adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules. (Exhibit G was formerly located following Section R9-21-505.)

EXHIBIT G

DEMAND FOR NOTICE BY RELATIVE OR VICTIM

(Pursuant to A.R.S. § 36-541.01)

REGARDING:_____

(Full Name of Patient)

Pursuant to A.R.S. § 36-541.01, with respect to the above-named patient, a person who was ordered to undergo treatment for a mental disorder as a danger to others pursuant to A.R.S. § 36-540 by a court order of the Superior Court of _____ County, Case Number _____, or who was committed by an Arizona tribal court, which order of commitment was duly domesticated pursuant to A.R.S. §§ 12-1702 et seq., the undersigned _____ relative _____victim does hereby demand that the medical director of _____ , the mental health treatment agency providing court-ordered treatment for said person, provide the undersigned with written notice of intention to release or discharge said person prior to the expiration of the period for treatment ordered by the Court, as provided for in A.R.S. § 36-541.01(D).

The undersigned person demanding notice hereby agrees to advise the treatment agency in writing, by certified mail, return receipt requested, of any change in the address to which notice is to be mailed.

_____

Signature of Applicant

_____

Printed or Typed Name of Applicant

_____

Date

_____

Address to Mail Notice

_____

Telephone Number of Applicant

ADHS/BHS Form MH-127 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit G repealed and a new Exhibit G adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Exhibit was adopted, repealed, and a new Exhibit adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules. (Exhibit H was formerly located following Section R9-21-505.)

EXHIBIT H
PETITION FOR NOTICE

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA IN AND FOR THE COUNTY OF _____

In the matter of	)	
	)	MH _____
	)	
	)	PETITION FOR NOTICE
	)	
	)	(Pursuant to A.R.S. § 36-541.01)
re: Mental Health Services	)	
	)	
_____)		

REGARDING:_____
(Full Name of Patient)

Pursuant to A.R.S. § 36-541.01, with respect to the above-named patient, a person who was ordered to undergo treatment for a mental disorder as a danger to others pursuant to A.R.S. § 36-540 by a court order of the Superior Court of _____ County, Case Number _____, the undersigned, a person other than a relative or victim of the person hereby asserting a legitimate reason for receiving such notice, does hereby petition the Court to require that the medical director of _____, the mental health treatment agency providing court-ordered treatment for said person, provide the undersigned with written notice of intention to release or discharge said person prior to the expiration of the period for treatment ordered by the Court, as provided for in A.R.S. § 36-541.01, and does hereby provide the following information required by A.R.S. § 36-541.01(D):

Legitimate reason for receiving notice: _____
_____
_____
_____

The undersigned person demanding notice hereby agrees to advise the treatment agency in writing, by certified mail, return receipt requested, of any change in the address to which notice is to be mailed.

_____
Signature of Person Petitioning

_____
Printed or Typed Name of Petitioner

_____
Date

_____
Address to Send Notice

_____
Telephone Number of Applicant

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA

IN AND FOR THE COUNTY OF _____

In the Matter of	)	
	)	MH
	)	
	)	ORDER FOR NOTICE
	)	
	)	
re: Mental Health Services	)	
	)	
	)	
	)	

1. The Court having received a demand by _____, a relative or victim of _____, a patient ordered by the Court to undergo treatment for a mental disorder as a danger to others, for written notice from the medical director of_____, the mental health treatment agency providing court-ordered treatment for said patient, of intention to release or discharge said patient prior to the expiration of the period ordered by the Court, as provided for in A.R.S. § 36-541.01, which demand included all information required by A.R.S. § 36-541.01(D);
2. The Court having received a petition by _____, a person other than a relative or victim of _____, a patient ordered by this Court to undergo treatment for a mental disorder as a danger to others, asserting that the petitioner has a legitimate reason for receiving such notice and petitioning the Court to require that the medical director of _____, the mental health treatment agency providing court-ordered treatment for said patient, provide the petitioner with written notice of intention to release or discharge said patient prior to the expiration of the period for treatment ordered by the Court, as provided for in A.R.S. §36-541.01, which petition included all information required by A.R.S. § 36-541.01(D); and the Court, after considering said petition, having found that the petitioner has a legitimate reason for receiving prior notice.

THEREFORE IT IS ORDERED that the medical director of _____, a mental health treatment agency, shall not release or discharge the above-named patient from court-ordered inpatient treatment without first giving written notice of the intention to do so, in accordance with A.R.S. § 36-541.01(F), to:

____ The above-named relative of the patient
____ The above-named victim of the patient
____ The above-named petitioner found by the Court to have a legitimate reason for receiving prior notice.

IT IS FURTHER ORDERED that a copy of this Order for Notice shall be delivered to the above-named mental health treatment agency and shall be filed with the patient's clinical record, and if the patient is transferred to another agency or institution, any orders for notice shall be transferred with the patient.

DATED this _____ day of _____, 19 _____

_____
SUPERIOR COURT JUDGE/COMMISSIONER

ADHS/BHS Form MH-128 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit H repealed, new Exhibit H adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-510. Voluntary Admission for Treatment

A. Application for admission for voluntary treatment pursuant to A.R.S. § 36-518 shall be made to a mental health agency on Department form MH-210, Titled "Application for Voluntary Treatment", set forth in Exhibit I, by any individual who:
1. Voluntarily makes application as provided in subsection (A);
2. Gives informed consent;
3. Has not been adjudicated as an incapacitated person pursuant to A.R.S. Title 14, Chapter 5, or Title 36, Chapter 5; and
4. If a minor, is appropriately admitted pursuant to A.R.S.§ 36-518.

B. Any mental health agency that is not a regional authority under R9-21-501 and that receives an application for voluntary treatment by a client shall immediately refer the client to the appropriate regional authority for treatment as provided under this rule, except that in the case of an emergency, a mental health treatment agency licensed by the Department to provide treatment under A.R.S. § 36-518 may accept an application for voluntary treatment and admit the client for treatment as follows:
1. Prior to admission of a client under this rule, the agency shall notify the appropriate regional authority of the potential admission and treatment so that the regional authority may first:
   a. Provide other services or treatment to the client as an alternative; or
   b. Authorize treatment of the client.
2. If the agency does not provide notice pursuant to subsection (B)(1) above, the regional authority shall not be obligated to pay for the treatment provided.

C. Any mental health agency providing treatment pursuant to A.R.S. § 36-518 shall place in the medical record of the individual to be treated the following:
1. A completed copy of the application for voluntary treatment;
2. A completed informed consent form pursuant to R9-21-511; and
3. A written statement of the individual's present mental condition.

D. If the client admitted under this rule does not have an ISP, the regional authority shall prepare one in accordance with Article 3 of this Chapter. If the client already has an ISP, the regional authority shall commence a review of the ISP as provided in R9-21-313 and, if necessary, take steps to modify the ISP in accordance with R9-21-314.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Exhibit was adopted, repealed, and a new Exhibit adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules. (Exhibit I was formerly located following Section R9-21-509.)

EXHIBIT I
APPLICATION FOR VOLUNTARY TREATMENT

(Pursuant to A.R.S. § 36-518)

I, _____, hereby request that the
(Person's Name)
_____place me in a program or agency for mental health treatment.
(Mental Health Agency)

I understand that my capacity to give informed consent to treatment will be determined before I am allowed to voluntarily consent to treatment. My informed consent to treatment will be given on a separate form.

Further, I am aware that I am entitled to:

1. Withdraw or modify my consent to treatment at any time.
2. Receive a booklet explaining my rights under Arizona law and assistance from a human rights advocate if I desire.
3. A fair explanation of the treatment I am to receive and the purposes of that treatment.
4. A description of any material and substantial risk reasonably to be expected as a result of the treatment.
5. An answer to my inquiries concerning treatment.
6. Revoke my consent to treatment at any time.
7. Discharge within 24 hours of my written request (excluding weekends and holidays) unless the medical director of the treatment agency files a petition for court-ordered treatment.

_____
Person's Signature

_____
Date

ADHS/BHS Form MH-210 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit I repealed, new Exhibit I adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3).

Editor's Note: The following Exhibit was adopted and repealed under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

EXHIBIT K. REPEALED

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-511. Informed Consent in Voluntary Application for Admission and Treatment

A. Prior to beginning any course of medication or other treatment for an individual who is subject to voluntary admission under A.R.S. §§ 36-518 and 36-522, a mental health agency shall obtain an informed consent to treatment and enter it in the medical record. For all clients, the informed consent shall be obtained pursuant to R9-21-206.

B. For clients, the mental health agency shall make reasonable inquiry into an individual's capacity to give informed consent, record these findings, and enter these findings in the client's ISP or record pursuant to Articles 2 and 3 of this Chapter. For non-clients, the agency shall adopt admission procedures that shall include the following:
1. The medical director or the medical director's designee shall make reasonable inquiry into an individual's capacity to give informed consent.
2. The medical director or the medical director's designee shall record his findings regarding the individual's capacity to give and of having given informed consent.
3. That the findings of the medical director or the medical director's designee shall be entered into the individual's record.

C. Consent to permit treatment may be revoked at any time by a reasonably clear statement in writing.
1. An individual shall receive assistance in writing the revocation as necessary.
2. If consent to permit treatment is revoked, treatment shall be promptly discontinued, provided that a course of treatment may be concluded or phased out where necessary to avoid the harmful effects of abrupt withdrawal.

D. An informed consent form shall be signed by the individual and shall state that the following information was presented to the individual:
1. A fair explanation of the treatments and their purposes.
2. A description of any material and substantive risk reasonably to be expected.
3. An offer to answer any inquiries concerning the treatments.
4. Notice that the individual is free to revoke consent to treatment; and
5. For clients, all information required by R9-21-206.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6. Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-512. Use of Psychotropic Medication

A. Psychotropic medications may only be ordered for individuals undergoing court-ordered evaluation pursuant to R9-21-204 or R9-21-207.

B. Psychotropic medications may not be ordered for and administered to individuals undergoing court-ordered treatment, except as follows:
1. In an emergency involving the safety of the individual or another, as documented in the individual's medical record;
2. If the individual or guardian gives an informed consent to use the medication;
3. If provision for use of the medications shall be contained in the individual's treatment plan or ISP. At a minimum, the plan shall specify:
   a. A description of the circumstances under which the medication may be used.
   b. A description of the objectives that are expected to be achieved by use of the medication. This description must indicate how the individual's condition would be improved by using the medication and indicate what result would be expected if the medication were not used; or
4. Pursuant to R9-21-204 or R9-21-207.

C. The agency shall have the capability to detect drug side effects or toxic reactions that may result from the medications used.

D. The agency shall have written policies and procedures governing the use of psychotropic medication. These policies and procedures shall specify:
1. Protective measures that will ensure the individual's safety and promote the avoidance or mitigation of short and long-term deleterious effects on the individual.
2. Periodic individual care monitoring, i.e., evaluating and updating the treatment plan and reviewing problem areas such as failure of the individual to achieve treatment plan objectives.
3. Recordkeeping requirements.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6.

Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings; and the Attorney General has not certified these rules.

R9-21-513. Seclusion and Restraint

Individuals undergoing court-ordered evaluation or court-ordered treatment may not be placed in seclusion or restraint except as permitted by Article 2 of this Chapter, and specifically R9-21-204.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

Editor's Note: This Chapter contains rules which were adopted or amended under an exemption from the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6), pursuant to Laws 1992, Ch. 301, § 61 and Ch. 302, § 13, and Laws 1993, Ch. 6, § 34. Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Governor's Regulatory Review Council did not review these rules; AHCCCS was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is being printed on blue paper.

ARTICLE 1. DEFINITIONS

New Article 1, consisting of Sections R9-22-101 through R9-22-103, R9-22-105, and R9-22-106 through R9-22-112 adopted effective December 8, 1997 (Supp. 97-4).

Former Article 1, consisting of Section R9-22-101, repealed effective December 8, 1997 (Supp. 97-4).

Section
R9-22-101. Location of Definitions
R9-22-102. Scope of Services Related Definitions
R9-22-103. Repealed
R9-22-104. Reserved
R9-22-105. General Provisions and Standards Related Definitions
R9-22-106. Request for Proposals (RFP) Related Definitions
R9-22-107. Standard for Payments Related Definitions
R9-22-108. Grievance and Appeal Process Related Definitions
R9-22-109. Quality Control Review and Analysis Related Definitions
R9-22-110. 1st- and 3rd-Party Liability Related Definitions
R9-22-112. Behavioral Health Services Related Definitions
R9-22-113. Reserved
R9-22-114. Title IV-A Related Definitions
R9-22-115. SSI MAO Related Definitions
R9-22-116. State-only Eligibility Related Definitions
R9-22-117. Enrollment Related Definitions

ARTICLE 2. SCOPE OF SERVICES

Section
R9-22-201. General Requirements
R9-22-202. Repealed
R9-22-203. Repealed
R9-22-204. Inpatient General Hospital Services
R9-22-205. Physician and Primary Care Physician and Practitioner Services
R9-22-206. Organ and Tissue Transplantation Services
R9-22-207. Dental Services
R9-22-208. Laboratory, Radiology and Medical Imaging Services
R9-22-209. Pharmaceutical Services
R9-22-210. Emergency Medical and Behavioral Health Services
R9-22-211. Transportation Services
R9-22-212. Medical Supplies, Durable Equipment, Orthotic and Prosthetic Devices
R9-22-213. Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)
R9-22-214. Repealed
R9-22-215. Other Medical Professional Services
R9-22-216. Nursing Facility Services
R9-22-217. Services Included in the State and Federal Emergency Services Programs
R9-22-218. Repealed

ARTICLE 3. REPEALED

Article 3, consisting of Sections R9-22-301 through R9-22-319 and R9-22-321 through R9-22-344, repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section R9-22-320 repealed December 13, 1993 (Supp. 93-4).

ARTICLE 4. CONTRACTS, ADMINISTRATION, AND STANDARDS

Section
R9-22-401. General
R9-22-402. Contracts
R9-22-403. Subcontracts
R9-22-404. Contract Amendments; Mergers; Reorganizations
R9-22-405. Suspension, Denial, Modification, or Termination of Contract
R9-22-406. Contract Compliance Sanction Alternative

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Section
R9-22-501. Pre-existing Conditions
R9-22-502. Availability and Accessibility of Service
R9-22-503. Reinsurance
R9-22-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions
R9-22-505. Approval of Advertisements and Marketing Materials
R9-22-506. Repealed
R9-22-507. Member Record
R9-22-508. Limitation of Benefit Coverage for Illness or Injury due to Catastrophe
R9-22-509. Transition and Coordination of Member Care
R9-22-510. Transfer of Members
R9-22-511. Fraud or Abuse
R9-22-512. Release of Safeguarded Information by the Administration and Contractors
R9-22-513. Discrimination Prohibition
R9-22-514. Equal Opportunity
R9-22-515. Repealed
R9-22-518. Information to Enrolled Members
R9-22-519. Repealed
R9-22-520. Financial Statements, Periodic Reports and Information
R9-22-521. Program Compliance Audits
R9-22-522. Quality Management/Utilization Management (QM/UM) Requirements
R9-22-523. Financial Resources
R9-22-524. Continuity of Care
R9-22-525. Repealed
R9-22-526. Renumbered
R9-22-527. Renumbered
R9-22-528. Renumbered
R9-22-529. Renumbered

ARTICLE 6. REQUEST FOR PROPOSALS (RFP)

Article 6, consisting of Sections R9-22-601 through R9-22-604, adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1).

Article 6, consisting of Sections R9-22-601 through R9-22-605, repealed by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1).

Article 6, consisting of Sections R9-22-601 through R9-22-604, adopted effective July 16, 1985.

Former Article 6, consisting of Sections R9-22-601 through R9-22-603, repealed effective October 1, 1983.

Section
R9-22-601. General Provisions
R9-22-602. Request for Proposals (RFP); Contract Award
R9-22-603. Contract Records
R9-22-604. Contract or Proposal Protests; Appeals
R9-22-605. Repealed

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-701. Scope of the Administration's Liability; Payments to Contractors
R9-22-702. Prohibitions Against Charges to Members or Eligible Persons
R9-22-703. Claims
R9-22-704. Transfer of payments
R9-22-705. Payments by Contractors
R9-22-706. Payments by the Administration for Services Provided to Eligible Persons
R9-22-707. Payments for Newborns
R9-22-708. Payment for services provided to eligible Native Americans residing on reservation
R9-22-709. Contractor's Liability to Hospitals for the Provision of Emergency and Subsequent Care
R9-22-710. Capped Fee-for-service Payments for Non-hospital Services
R9-22-711. Copayments
R9-22-712. Payments by the Administration for Hospital Services
R9-22-713. Payments made on behalf of a contractor; recovery of indebtedness
R9-22-714. Contractor risk retention fund (AHCCCS-assembled networks)
R9-22-715. Hospital Rate Negotiations
R9-22-716. Specialty Contracts
R9-22-717. Hospital Claims Review
R9-22-718. Inpatient Hospital Reimbursement Pilot Program

ARTICLE 8. GRIEVANCE AND APPEAL PROCESS

Section
R9-22-801. General Provisions For All Grievances and Appeals
R9-22-802. Eligibility Appeals for Applicants, Eligible Persons, and Members Receiving State-funded AHCCCS Services
R9-22-803. Eligibility Appeals for Applicants, Eligible Persons, and Members Receiving SSI-related Medical Assistance Only AHCCCS Services
R9-22-804. Grievances
R9-22-805. Repealed

ARTICLE 9. QUALITY CONTROL REVIEW AND ANALYSIS

Article 22, consisting of Sections R9-22-901 through R9-22-908, adopted effective August 29, 1985.

Former Article 22, consisting of Section R9-22-901, repealed effective October 1, 1983.

Section
R9-22-901. Definitions
R9-22-902. Certification Errors
R9-22-903. County responsibilities
R9-22-904. Quality control review challenge process
R9-22-905. Quality control analysis challenge process
R9-22-906. Corrective Action Plans for Certification Errors
R9-22-907. Recovery of cost for covered services
R9-22-908. Repealed

ARTICLE 10. 1ST- AND 3RD-PARTY LIABILITY AND RECOVERIES

Article 10, consisting of Section R9-22-1001 through R9-22-1002, adopted effective November 7, 1997 (Supp. 97-4).

Article 10, consisting of Section R9-22-1001 through R9-22-1002, repealed effective November 7, 1997 (Supp. 97-4).

Article 10 consisting of Sections R9-22-1001 and R9-22-1002 adopted effective October 1, 1985.

Section
R9-22-1001. 1st-and 3rd-Party Liability and Coordination of Benefits
R9-22-1002. 1st-and 3rd-Party Liability Monitoring and Compliance

ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS

Article 11 consisting of Sections R9-22-1101 through R9-22-1104 adopted effective October 1, 1986.

Section
R9-22-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims
R9-22-1102. Determinations Regarding the Amount of the Penalty and Assessment
R9-22-1103. Notice of Proposed Determination and Rights of Parties
R9-22-1104. Issues and Burden of Proof

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

Article 12, consisting of Sections R9-22-1201 through R9-22-1206, adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Governor's Regulatory Review Council did not review these rules; AHCCCS was not required to hold public hearing on this rulemaking; and the Attorney General has not certified these rules.

Section
R9-22-1201. Definitions
R9-22-1202. Eligibility
R9-22-1203. Service Delivery System and Referral
R9-22-1204. Covered Behavioral Health Services for Eligible Persons and Members
R9-22-1205. Qualifications and Standards of Participation for Service Providers
R9-22-1206. Payments
R9-22-1207. Grievance and Appeal Process

ARTICLE 13. MEMBERS' RIGHTS AND RESPONSIBILITIES

Article 13, consisting of Sections R9-22-1301 through R9-22-1309, adopted effective September 9, 1998 (Supp. 98-3).

Section

R9-22-1301. General Intent and Definitions
R9-22-1302. Denial of a Request for a Service
R9-22-1303. Reduction, Suspension, or Termination of a Service
R9-22-1304. Content of Notice
R9-22-1305. Exceptions from an Advance Notice
R9-22-1306. Notice in a Case of Probable Fraud
R9-22-1307. Expedited Hearing Process
R9-22-1308. Maintenance of Records
R9-22-1309. Member Handbook

ARTICLE 14. TITLE IV-A RELATED ELIGIBILITY

Article 14, consisting of Sections R9-22-1401 through R9-22-1436, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Section
R9-22-1401. Scope and Applicability
R9-22-1402. Agency Responsible for Determining Eligibility
R9-22-1403. Confidentiality
R9-22-1404. Case Record
R9-22-1405. Manuals
R9-22-1406. Eligibility Coverage Groups and an Eligible Applicant
R9-22-1407. Application
R9-22-1408. Applicant and Recipient Responsibility
R9-22-1409. Death of an Applicant
R9-22-1410. Withdrawal of Application
R9-22-1411. Initial Eligibility Interview
R9-22-1412. Withdrawal from the Medical Assistance Program
R9-22-1413. Verification of Eligibility Information
R9-22-1414. Processing the Application - Approvals and Denials
R9-22-1415. Review
R9-22-1416. Notice of Termination Action
R9-22-1417. Reinstatement of Medical Assistance
R9-22-1418. Dependent Child Living with Specified Relative
R9-22-1419. Assistance Unit
R9-22-1420. Deprivation
R9-22-1421. Application for Other Benefits
R9-22-1422. Assignment of Rights; Cooperation
R9-22-1423. Social Security Number
R9-22-1424. State Residency
R9-22-1425. Citizenship and Alien Status
R9-22-1426. Resources
R9-22-1427. Determining Resource Eligibility
R9-22-1428. Income
R9-22-1429. Earned Income Disregards
R9-22-1430. Determining Income Eligibility
R9-22-1431. Effective Date of Eligibility
R9-22-1432. Prior Quarter Eligibility
R9-22-1433. Deemed Newborn Eligibility
R9-22-1434. Extended Medical Assistance Coverage for a Pregnant Woman
R9-22-1435. Family Planning Services Extension Program
R9-22-1436. Eligibility Appeals

ARTICLE 15. SSI MAO ELIGIBILITY

Article 15, consisting of Sections R9-22-1501 through R9-22-1508, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Section
R9-22-1501. SSI Medical Assistance Only (MAO) Coverage Groups
R9-22-1502. Eligibility Determination Process
R9-22-1503. State Residency
R9-22-1504. Citizenship and Qualified Alien Status
R9-22-1505. Social Security Enumeration
R9-22-1506. Resource Criteria for SSI MAO Eligibility
R9-22-1507. Income Criteria for Eligibility
R9-22-1508. Changes and Redeterminations

ARTICLE 16. STATE-ONLY ELIGIBILITY

Article 16, consisting of Sections R9-22-1601 through R9-22-1613, R9-22-1615 through R9-22-1620, R9-22-1622 through R9-22-1631, R9-22-1633, R9-22-1634, and R9-22-1636, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Section
R9-22-1601. Who May Apply for MI/MN Benefits
R9-22-1602. Application for MI/MN Benefits
R9-22-1603. Priority Applications for MI/MN Eligibility
R9-22-1604. MI/MN Applications for Applicants Facing a Loss of Categorically Eligible Status Due to Termination of SSI Benefits
R9-22-1605. Responsibilities of the Head-of-household for MI/MN Eligibility
R9-22-1606. MI/MN Statement of Truth by the Head-of-household
R9-22-1607. Notice of Reapplication
R9-22-1608. County Responsibility for Completion of MI/MN Eligibility Determination
R9-22-1609. MI/MN Timeliness Requirements
R9-22-1610. Forwarding Applications to Obtain Categorical Eligibility
R9-22-1611. Eligibility for Medicare Beneficiaries
R9-22-1612. State-funded Coverage for Children
R9-22-1613. State Emergency Service Program (SESP)
R9-22-1614. Reserved
R9-22-1615. Certification Periods
R9-22-1616. Denial or Discontinuance of MI/MN Eligibility
R9-22-1617. Notice of Action for Eligibility
R9-22-1618. Communication of Eligibility Determinations to the Administration
R9-22-1619. Rights Following Receipt of a Notice of Denial or Discontinuance of Coverage
R9-22-1620. Retroactive Coverage for MI/MN, ELIC, and SESP
R9-22-1621. Reserved
R9-22-1622. Verification of Information for MI/MN Eligibility
R9-22-1623. Residence Requirements for MI/MN Eligibility
R9-22-1624. Citizenship and Alien Status Requirements for MI/MN Eligibility
R9-22-1625. Household Composition for MI/MN Eligibility
R9-22-1626. Annual Income for MI/MN Eligibility
R9-22-1627. Resources for MI/MN Eligibility
R9-22-1628. Transfer of Resources for MI/MN Eligibility
R9-22-1629. Assignment of Rights
R9-22-1630. MI/MN Interim Changes
R9-22-1631. MI/MN Redeterminations
R9-22-1632. Reserved
R9-22-1633. Case Record for MI/MN Applications
R9-22-1634. Eligibility Office Locations and Hours of Operation
R9-22-1635. Reserved
R9-22-1636. Verification Review by the Director

ARTICLE 17. ENROLLMENT

Article 17, consisting of Sections R9-22-1701 through R9-22-1704, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Section
R9-22-1701. Enrollment of a Member with an AHCCCS Contractor

R9-22-1702. Effective Date of Enrollment with a Contractor and Notification to the Contractor
R9-22-1703. Newborn Enrollment
R9-22-1704. Categorical and EAC Guaranteed Enrollment Period

ARTICLE 1. DEFINITIONS

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify the rule. This Section was subsequently amended, repealed, and a new Section adopted through the regular rulemaking process.

R9-22-101. Location of Definitions

A. Location of definitions. Definitions applicable to this Chapter are found in the following:

	Definition	Section or Citation
1.	"210"	R9-22-114
2.	"1931"	R9-22-114
3.	"1-time income"	R9-22-116
4.	"1st-party liability"	R9-22-110
5.	"3-month income period"	R9-22-116
6.	"3rd-party"	R9-22-110
7.	"3rd-party liability"	R9-22-110
8.	"Accommodation"	R9-22-107
9.	"Act"	R9-22-114
10.	"Acute mental health services"	R9-22-112
11.	"Adequate notice"	R9-22-114
12.	"Administration"	R9-22-106, R9-22-114, and A.R.S. § 36-2901
13.	"Adverse action"	R9-22-114
14.	"AEC"	R9-22-117
15.	"Affiliate corporate organization"	R9-22-106
16.	"Aged"	R9-22-115
17.	"Aggregate"	R9-22-107
18.	"AHCCCS"	R9-22-101
19.	"AHCCCS hearing officer"	R9-22-108
20.	"AHCCCS inpatient hospital day or days of care"	R9-22-107
21.	"Ambulance"	R9-22-102
22.	"Ancillary department"	R9-22-107
23.	"Annual enrollment choice"	R9-22-117
24.	"Appeal"	R9-22-108
25.	"Appellant"	R9-22-114
26.	"Applicant"	R9-22-101
27.	"Application"	R9-22-101
28.	"Assignment"	R9-22-101
29.	"Assistance unit"	R9-22-114
30.	"Authorized representative"	R9-22-114
31.	"Auto-assignment algorithm"	R9-22-117
32.	"Baby Arizona"	R9-22-114
33.	"BHS"	R9-22-114
34.	"Billed charges"	R9-22-107
35.	"Blind"	R9-22-115
36.	"Bona fide funeral agreement"	R9-22-114
37.	"Burial plot"	R9-22-114
38.	"Capital costs"	R9-22-107
39.	"Capped fee-for-service"	R9-22-101
40.	"Caretaker relative"	R9-22-114
41.	"Case record"	R9-22-101
42.	"Cash assistance"	R9-22-114
43.	"Categorically eligible"	A.R.S. §§ 36-2901(4)(b) and 36-2934
44.	"Certification error"	A.R.S. § 36-2905.01
45.	"Certification period"	R9-22-115 and R9-22-116
46.	"Child welfare agency"	R9-22-114
47.	"Clean claim"	A.R.S. § 36-2904
48.	"CMDP"	R9-22-117
49.	"Continuous stay"	R9-22-101
50.	"Contract"	R9-22-101
51.	"Contractor"	R9-22-101
52.	"Contractor of record"	R9-22-101
53.	"Copayment"	R9-22-107
54.	"Cost-to-charge ratio"	R9-22-107
55.	"Countable income"	R9-22-116
56.	"County eligibility staff"	R9-22-116
57.	"Covered charges"	R9-22-107
58.	"Covered services"	R9-22-102
59.	"CPT"	R9-22-107
50.	"CRS"	R9-22-114
61.	"Date of determination"	R9-22-116
62.	"Date of discontinuance"	R9-22-116
63.	"Date of enrollment action"	R9-22-117
64.	"Day"	R9-22-101
65.	"DCSE"	R9-22-114
66.	"Deductible medical expense"	R9-22-116
67.	"Deemed application date"	R9-22-116
68.	"Dentures"	R9-22-102
69.	"Department"	R9-22-114
70.	"Dependent child"	R9-22-114 and R9-22-116
71.	"DES"	R9-22-101
72.	"Determination"	R9-22-116
73.	"Diagnostic services"	R9-22-102
74.	"Disabled"	R9-22-115
75.	"Discontinuance"	R9-22-116
76.	"Discussions"	R9-22-106
77.	"Disenrollment"	R9-22-117
78.	"District Medical Consultant"	R9-22-114
79.	"DME"	R9-22-102
80.	"DRI inflation factor"	R9-22-107
81.	"E.P.S.D.T. services"	R9-22-102
82.	"EAC"	R9-22-101
83.	"Earned income"	R9-22-116
84.	"Educational income"	R9-22-116
85.	"ELIC"	R9-22-101
86.	"Eligibility determination date"	R9-22-114
87.	"Eligible assistance children"	A.R.S. § 36-2905.03(B)
88.	"Eligible applicant"	A.R.S. § 36-2901(4)
89.	"Eligible low income children"	A.R.S. § 36-2905.03(C) and (D)
90.	"Emancipated minor"	R9-22-116
91.	"Emergency medical condition"	42 U.S.C. 1396b(v)
92.	"Emergency medical services"	R9-22-102
93.	"Encounter"	R9-22-107
94.	"Enrollment"	R9-22-117
95.	"Enumeration"	R9-22-101
96.	"Equity"	R9-22-101
97.	"Expressly emancipated minor"	R9-22-116
98.	"FAA" or "Family Assistance Administration"	R9-22-114
99.	"Facility"	R9-22-101
100.	"Factor"	R9-22-101
101.	"FBR"	R9-22-101
102.	"Federal Benefit Rate"	R9-22-101
103.	"Federal emergency services program"	R9-22-101
104.	"FESP"	R9-22-101
105.	"Foster care maintenance payment"	R9-22-114
106.	"Foster child"	R9-22-114
107.	"FPL"	R9-22-114

108.	"FQHC"	R9-22-101
109.	"Grievance"	R9-22-108
110.	"GSA"	R9-22-101
111.	"Guardian"	R9-22-116
112.	"Head-of-household"	R9-22-116
113.	"Hearing aid"	R9-22-102
114.	"Home health services"	R9-22-102
115.	"Homebound"	R9-22-114
116.	"Hospital"	R9-22-101
117.	"Hospitalized"	R9-22-116
118.	"ICU"	R9-22-107
119.	"IHS"	R9-22-117
120.	"Income"	R9-22-114 and R9-22-116
121.	"Income-in-kind"	R9-22-116
122.	"Indigent"	A.R.S. § 11-297
123.	"Inmate of a public institution"	42 CFR 435.1009
124.	"Interested party"	R9-22-106
125.	"Interim change"	R9-22-116
126.	"JTPA" or "Job Training Partnership Act"	R9-22-114
127.	"License" or "licensure"	R9-22-101
128.	"Liquid assets"	R9-22-114 and R9-22-116
129.	"Liquid resources"	R9-22-116
130.	"Lump-sum income"	R9-22-116
131.	"Mailing date"	R9-22-114
132.	"Medical education costs"	R9-22-107
133.	"Medical record"	R9-22-101
134.	"Medical review"	R9-22-107
135.	"Medical services"	R9-22-101
136.	"Medical supplies"	R9-22-102
137.	"Medical support"	R9-22-114
138.	"Medically necessary"	R9-22-101
139.	"Medicare claim"	R9-22-107
140.	"Medicare HMO"	R9-22-101
141.	"MI/MN"	A.R.S. § 36-2901(4)(a) and (c)
142.	"Minor parent"	R9-22-114
143.	"Month of determination"	R9-22-116
144.	"New hospital"	R9-22-107
145.	"NICU"	R9-22-107
146.	"Noncontracting provider"	A.R.S. § 36-2931
147.	"Nonliquid resources"	R9-22-116
148.	"Nonparent caretaker relative"	R9-22-114
149.	"Nursing facility"	42 U.S.C. 1396r(a)
150.	"Occupational therapy"	R9-22-102
151.	"Offeror"	R9-22-106
152.	"Operating costs"	R9-22-107
153.	"Outlier"	R9-22-107
154.	"Outpatient hospital service"	R9-22-107
155.	"Ownership change"	R9-22-107
156.	"Peer group"	R9-22-107
157.	"Pharmaceutical service"	R9-22-102
158.	"Physical therapy"	R9-22-102
159.	"Physician"	R9-22-102
160.	"Post-stabilization services"	42 CFR 438.114
161.	"Practitioner"	R9-22-102
162.	"Pre-enrollment process"	R9-22-114
163.	"Prescription"	R9-22-102
164.	"Primary care provider"	R9-22-102
165.	"Primary care provider services"	R9-22-102
166.	"Prior authorization"	R9-22-102
167.	"Private duty nursing services"	R9-22-102
168.	"Proposal"	R9-22-106
169.	"Proposal of discontinuance"	R9-22-116
170.	"Prospective rate year"	R9-22-107
171.	"Prospective rates"	R9-22-107
172.	"Prudent layperson standard"	42 U.S.C. 1396u-2
173.	"Public assistance"	R9-22-116
174.	"Quality management"	R9-22-105
175.	"Radiology"	R9-22-102
176.	"Rebasing"	R9-22-107
177.	"Recipient"	R9-22-114
178.	"Redetermination"	R9-22-116
179.	"Referral"	R9-22-101
180.	"Rehabilitation services"	R9-22-102
181.	"Reinsurance"	R9-22-107
182.	"Resources"	R9-22-114 and R9-22-116
183.	"Respiratory therapy"	R9-22-102
184.	"Responsible offeror"	R9-22-106
185.	"Responsive offeror"	R9-22-106
186.	"Review"	R9-22-114
187.	"RFP"	R9-22-105 and R9-22-106
188.	"Scope of services"	R9-22-102
189.	"SDAD"	R9-22-107
190.	"Separate property"	A.R.S. § 25-213
191.	"Service location"	R9-22-101
192.	"Service site"	R9-22-101
193.	"SESP"	R9-22-101
194.	"S.O.B.R.A."	R9-22-101
195.	"Specialist"	R9-22-102
196.	"Specified relative"	R9-22-114 and R9-22-116
197.	"Speech therapy"	R9-22-102
198.	"Spendthrift restriction"	R9-22-114
199.	"Spouse"	R9-22-101
200.	"SSA"	P.L. 103-296, Title I
201.	"SSI"	R9-22-101
202.	"SSN"	R9-22-101
203.	"State alien"	R9-22-101
204.	"State emergency services program"	R9-22-101
205.	"Sterilization"	R9-22-102
206.	"Subcontract"	R9-22-101
207.	"SVES" or "State Verification and Exchange System"	R9-22-114
208.	"Tier"	R9-22-107
209.	"Tiered per diem"	R9-22-107
210.	"Title IV-A"	R9-22-114
211.	"Title IV-D"	R9-22-114
212.	"Title IV-E"	R9-22-114
213.	"TMA"	R9-22-114
214.	"Total inpatient hospital days"	R9-22-107
215.	"Unearned income"	R9-22-116
216.	"Utilization management"	R9-22-105

B. General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to an eligible person.
2. "Applicant" means a person who submits or whose representative submits, a written, signed, and dated application for AHCCCS benefits that has not been approved or denied.
3. "Application" means an official request for medical assistance made under this Chapter.
4. "Assignment" means enrollment of an eligible person with a contractor by the Administration.
5. "Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific AHCCCS-covered ser-

vice and equipment provided to an eligible applicant. A payments is made in accordance with an upper, or capped, limit established by the Director.

6. "Case record" means the file and all documents in the file that are used to establish eligibility.
7. "Categorically eligible" means a person who is eligible as defined by A.R.S. §§ 36-2901(4)(b) and 36-2934.
8. "Continuous stay" means the period of time during which an eligible person receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.
9. "Contract" means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and these rules.
10. "Contractor" means a person, an organization, or an entity that agrees, through a direct contracting relationship with the Administration, to provide goods and services specified by the contract under the requirements of the contract and these rules.
11. "Contractor of record" means an organization or an entity in which a person is enrolled for the provision of AHCCCS services.
12. "Day" means a calendar day unless otherwise specified in the text.
13. "DES" means the Department of Economic Security.
14. "EAC" means eligible assistance children.
15. "ELIC" means eligible low-income children.
16. "Eligible assistance children" means the children defined by A.R.S. § 36-2905.03(B).
17. "Eligible low-income children" means the children defined by A.R.S. § 36-2905.03(C) and (D).
18. "Eligible applicant" means the applicant defined in A.R.S. § 36-2901(4).
19. "Enumeration" means the assignment of a specific 9-digit identification number to a person by the Social Security Administration.
20. "Equity" means the county assessor full cash or market value of a resource minus valid liens, encumbrances, or both.
21. "Facility" means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution, under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related services.
22. "Factor" means an organization, a collection agency, a service bureau, or a person who advances money to a provider for accounts receivable that the provider assigns, sells, or otherwise transfers, including transfers through the use of a power of attorney, to the organization, the collection agency, the service bureau, or the person that receives an added fee or a deduction of a portion of the face value of the accounts receivable in return for the advanced money. The term "factor" does not include a business representative, such as a bailing agent or an accounting firm described within these rules, or a health care institution.
23. "FBR" means Federal Benefit Rate, defined in R9-22-101(B)(24).
24. "Federal Benefit Rate" means the maximum monthly Supplemental Security Income payment rate for an eligible person or a married couple.
25. "Federal emergency services program" means a program designed to provide emergency medical services covered under 42 U.S.C. 1396b(v), to treat an emergency medical condition for a categorically eligible person who is determined eligible under A.R.S. § 36-2903.03.
26. "FESP" means federal emergency services program.
27. "FQHC" means federally qualified health center.
28. "GSA" means a geographical service area designated by the Administration within which a contractor of record provides, directly or through a subcontract, a covered health care service to a member enrolled with that contractor of record.
29. "Hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined to meet the requirements of certification.
30. "Indigent" means meeting eligibility criteria under A.R.S. § 11-297.
31. "Inmate of a public institution" means a person defined by 42 CFR 435.1009.
32. "License" or "licensure" means a nontransferable authorization that is based on established standards in law, is issued by a state or a county regulatory agency or board, and allows a health care provider to render a health care service lawfully.
33. "Medical record" means all documents that relate to medical and behavioral health services provided to an eligible person, a physician, or other licensed practitioner of the healing arts or member and that are kept at the site of the provider.
34. "Medical services" means health care services provided to an eligible person by a physician, a practitioner, a dentist, or by a health professional and technical personnel under the direction of a physician, a practitioner, or a dentist.
35. "Medically necessary" means a covered service provided by a physician or other licensed practitioner of the healing arts and within the scope of practice under state law to:
    a. Prevent disease, disability, and other adverse health conditions or their progression; or
    b. Prolong life.
36. "Medicare HMO" means a health maintenance organization that has a current contract with the Health Care Financing Administration (HCFA) for participation in the Medicare program under 42 CFR 417(L).
37. "MI/MN" means medically indigent and medically needy defined in A.R.S. § 36-2901(4)(a) and (c).
38. "Nursing facility" means a nursing facility defined in 42 U.S.C. 1396r(a).
39. "Noncontracting provider" means the provider defined in A.R.S. § 36-2931.
40. "Referral" means the process by which an eligible person is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.
41. "Separate property" means property defined in A.R.S. § 25-213.
42 "Service location" means any location at which a member obtains any health care service provided by a contractor of record under the terms of a contract.
43. "Service site" means a location designated by a contractor of record as the location at which a person is to receive health care services.
44. "SESP" means state emergency services program.
45. "S.O.B.R.A." means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medi-

care Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(ii)(IX), July 1, 1988.

46. "Spouse" means the husband or wife who has entered into a contract of marriage, recognized as valid by Arizona.
47. "SSA" means Social Security Administration defined in P.L. 103-296, Title I.
48. "SSI" means Supplemental Security Income under Title XVI of the Social Security Act, as amended.
49. "SSN" means social security number.
50. "State alien" means an unqualified alien described in A.R.S. § 36-2903.03(C).
51. "State emergency services program" means a program designed to provide emergency medical services identified as covered under R9-22-217 to treat an emergency medical condition for a person who is determined eligible under A.R.S. § 36-2905.05.
52. "Subcontract" means an agreement entered into by a contractor with any of the following:
    a. A provider of health care services who agrees to furnish covered services to a member;
    b. A marketing organization; or
    c. Any other organization or person who agrees to perform any administrative function or service for a contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a contract.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-101 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-101 repealed, former Sections R9-22-102 and R9-22-301 renumbered as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency by adding new paragraphs (24), (46), (84) and (91) and renumbering accordingly effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Amended as an emergency by adding new paragraphs (2) and (15) and renumbering accordingly effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment added paragraphs (2) and (15) and renumbered accordingly effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended paragraphs (10) and (15) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended by deleting paragraphs (39) and (62) and renumbering accordingly effective July 1, 1988 (Supp. 88-3). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted effective December 8, 1997 (Supp. 97-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1).

R9-22-102. Scope of Services Related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "Ambulance" means a medical transport vehicle that is registered by and part of an ambulance service licensed by the Arizona Department of Health Services according to A.R.S. Title 36, Chapter 21.1, and 19 A.A.C. 13; and includes ground, air, and water ambulances that are staffed and equipped as a basic life support (BLS) vehicle or an advanced life support (ALS) vehicle. Ambulances may be used to provide:
    a. Emergency transportation for eligible persons or members requiring emergency medical services; or
    b. Medically necessary transportation from 1 medical facility to another; and
    c. Any necessary emergency medical services that a certified emergency medical technician (EMT), an Intermediate EMT or paramedic, a registered nurse or a physician assistant, provides before, during, or after transportation.
2. "Covered services" means the health and medical services described in Articles 2 and 12.
3. "Dentures" means a partial or complete set of artificial teeth and services that are determined to be medically necessary, and the primary treatment of choice, or an essential part of an overall treatment plan, designed to alleviate a medical condition as determined by the primary care provider in consultation with the dental service provider.
4. "Diagnostic services" means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.
5. "DME" means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.
6. "Emergency medical condition" has meaning in 42 U.S.C. 1396b(v).
7. "Emergency medical services" means services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:
    a. Placing the patient's health in serious jeopardy;
    b. Serious impairment to bodily functions; or
    c. Serious dysfunction of any bodily organ or part.
8. "E.P.S.D.T. services" means early and periodic screening, diagnosis, and treatment services for eligible persons or members less than 21 years of age. For the purpose of these rules:
    a. "Early" means, in the case of an eligible person less than 21 years of age, as early as possible in the person's life or, in other cases, as soon as the person becomes eligible;
    b. "Periodic" means at appropriate intervals established by the Administration for screening to ensure

that a condition, illness, or injury is not incipient or present;

c. "Screening" means the use of quick, simple procedures carried out among large groups of people to distinguish apparently well persons from those who may have a condition, illness, or injury and the identification of those in need of more definitive study. For the purposes of AHCCCS, screening and diagnosis are not synonymous;

d. "Diagnosis" means the determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental and psychological examination, laboratory tests, X-rays; and

e. "Treatment" means any type of health care or service recognized under the state Plan submitted according to Title XIX of the Social Security Act to prevent or ameliorate a condition, illness, or injury or prevent or correct abnormalities detected by screening or diagnostic procedures.

9. "Hearing aid" means a wearable instrument or device designed for, or represented as aiding or compensating for impaired or defective human hearing, and any parts, attachments, or accessories of the instrument or device.
10. "Home health services" means the services that are provided by a home health agency that coordinates in-home intermittent services for curative, habilitative care. This includes home-health aide services, licensed nurse services, and medical supplies, equipment, and appliances.
11. "Medical supplies" means consumable items that are designed specifically to meet a medical purpose.
12. "Occupational therapy" means the medically prescribed treatment provided by or under the supervision of a licensed occupational therapist, to restore or improve an individual's ability to perform tasks required for independent functioning.
13. "Pharmaceutical service" means medically necessary medications that are prescribed by a physician, practitioner, or dentist, and are dispensed by a licensed pharmacist through a registered pharmacy.
14. "Physical therapy" means treatment services to restore or improve muscle tone, joint mobility, or physical function provided by or under the supervision of a registered physical therapist.
15. "Physician" means a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17.
16. "Practitioner" means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15.
17. "Prescription" means an order to provide covered services, which is signed or transmitted by a provider authorized to prescribe or order services.
18. "Primary care provider" means an individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of a member's or eligible person's health care.
19. "Primary care provider services" means healthcare services provided by and within the scope of practice, as defined by law, of a licensed physician, certified nurse practitioner, or licensed physician assistant.
20. "Prior authorization" means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services contingent on their medical necessity.
21. "Private duty nursing services" means nursing services provided to a member or eligible person who requires more individual and continuous care than is available from a visiting nurse, or routinely provided by the nursing staff of a nursing facility or ICF-MR, and that are provided by a registered nurse or licensed practical nurse.
22. "Radiology" means professional and technical services rendered to provide medical imaging, radioisotope services, and radiation oncology.
23. "Rehabilitation services" means physical, occupational, and speech therapies, and items to assist in improving or restoring a person's functional level.
24. "Respiratory therapy" means treatment services to restore, maintain, or improve respiratory functions and is provided by, or under the supervision of, a respiratory therapist licensed according to A.R.S. Title 32, Chapter 35.
25. "Scope of services" means the covered, limited, and excluded services under Articles 2 and 12 of these rules.
26. "Specialist" means a Board eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty.
27. "Speech therapy" means medically prescribed diagnostic and treatment services provided by, or under the supervision of, a certified speech therapist.
28. "Sterilization" means a medically necessary procedure, not for purpose of family planning, to render an eligible person or member barren in order to:
    a. Prevent the progression of disease, disability, or adverse health conditions; or
    b. Prolong life and promote physical health.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-102 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1092 (Supp. 82-4). Former Section R9-22-102 renumbered together with former Section R9-22-301 as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). New Section adopted effective December 8, 1997 (Supp. 97-4).

R9-22-103. Repealed

Historical Note

Adopted effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-104. Reserved

R9-22-105. General Provisions and Standards Related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "Quality management" means a methodology and activities used by professional health personnel through a formal program involving multiple organizational components and committees to:
    a. Assess the degree of conformance to desired medical standards and practices and;
    b. Improve or maintain quality service and care.
2. "RFP" means a request for proposals which is a document prepared by the Administration that describes the services required and that instructs prospective offerors how to prepare a response (proposal).

3. "Utilization management" means a methodology used by professional health personnel that assesses the medical indications, appropriateness, and efficiency of care provided.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4).

R9-22-106. Request for Proposals (RFP) Related Definitions
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "Administration" means the Arizona Health Care Cost Containment System Administration, its agents, employees, and designated representatives.
2. "Affiliated corporate organization" means any organization that has ownership or management interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation relationships. 42 CFR 455.101, September 30, 1986, is incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
3. "Discussions" means an oral or written exchange of information or any form of negotiation.
4. "Interested party" means an actual or prospective offeror whose economic interest may be directly affected by the issuance of an RFP, the award of a contract, or by the failure to award a contract.
5. "Offeror" means a person or other entity that submits a proposal to the Administration in response to an RFP.
6. "Proposal" means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.
7. "Responsible offeror" means a person or entity who has the capability to perform the contract requirements and which will ensure good faith performance.
8. "Responsive offeror" means a person or entity that submits a proposal that conforms in all material respects to an RFP.
9. "RFP" means Request for Proposals, including all documents, whether attached or incorporated by reference, which are used by the Administration for soliciting a proposal under Article 6.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1).

R9-22-107. Standard for Payments Related Definitions
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "Accommodation" means the bed and board services provided to a patient during an inpatient hospital stay and includes the cost of all staffing, supplies, and equipment. The accommodation is typically semi-private except when the member must be isolated for medical reasons. Other types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit in which bed and board are provided.
2. "Aggregate" means the combined amount of hospital payments for covered services provided within and outside the service area.
3. "AHCCCS inpatient hospital day or days of care" means the period of time beginning with the day of admission and includes each day of an inpatient stay for an eligible person, including the day of death, but excluding the day of discharge, provided that all medical necessity and medical review requirements are met.
4. "Ancillary department" means the department of a hospital that provides ancillary services and outpatient services, which are defined in the Medicare Provider Reimbursement Manual.
5. "Billed charges" means charges that a hospital includes on a claim for providing hospital services to an eligible person or member consistent with the rates and charges filed by the hospital with the Arizona Department of Health Services.
6. "Capital costs" means capital-related costs, which are defined in the Medicare Provider Reimbursement Manual, Chapter 28, such as building and fixtures, and movable equipment.
7. "Clean claim" has the meaning in A.R.S. § 36-2904.
8. "Copayment" means a monetary amount, specified by the Director, that a member pays directly to a contractor or provider at the time covered services are rendered.
9. "Cost-to-charge ratio" means a hospital's costs for providing covered services divided by the hospital's covered charges for the same services.
10. "Covered charges" means billed charges that represent medically necessary, reasonable, and customary items of expense for AHCCCS-covered services that meet medical review criteria of the Administration or contractor.
11. "CPT" means current procedural terminology, the manual published and updated by the American Medical Association, which is a nationally accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and provides a uniform language that will accurately designate medical, surgical, and diagnostic services.
12. "DRI inflation factor" means the Data Resources Inc., Health Care Financing Administration-type hospital input price index for prospective hospital reimbursement, which is published by DRI/McGraw-Hill.
13. "Encounter" means a record of medical service, submitted by a contractor and processed by AHCCCS, that is rendered by a provider registered with AHCCCS to a member who is enrolled with the contractor on the date of service, and for which the contractor incurs any financial liability.
14. "ICU" means the intensive care unit of a hospital.
15. "Medical education costs" means direct hospital costs for intern and resident salaries, fringes, and program costs, nursing school education, and paramedical education, which is defined in the Medicare Provider Reimbursement Manual, Chapter 28.
16. "Medical review" means a review involving clinical judgment of a claim or a request for a service before or after it is paid or rendered to ensure that services provided to an eligible person or member are medically necessary and covered services and that required authorizations are obtained by the provider. The criteria for medical review are established by the Administration or contractor based on medical practice standards that are updated periodically to reflect changes in medical care.
17. "Medicare claim" means a claim for Medicare covered services for an eligible person or member with Medicare coverage.
18. "New hospital" means any hospital for which Medicare Cost Report data and claim and encounter data are not available for hospital rate development from any owner or operator of the hospital, during either the initial prospective rate year or rebasing.

19. "NICU" means the neonatal intensive care unit of a hospital that has been classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.
20. "Operating costs" means allowable accommodation and ancillary department hospital costs excluding capital and medical education costs.
21. "Outlier" means a hospital claim or encounter in which the AHCCCS inpatient hospital days of care have operating costs per day that meet the criteria described in R9-22-712.
22. "Outpatient hospital service" means a service provided in an outpatient hospital setting that does not result in an admission.
23. "Ownership change" means a change in a hospital's owner, lessor, or operator as defined in 42 CFR 489.18(A).
24. "Peer group" means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services.
25. "Prospective rates" means inpatient or outpatient hospital rates defined in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, non-categorical discounts, and 1st-and 3rd-party payments regardless of billed charges or individual hospital costs.
26. "Prospective rate year" means the period from October 1 of each year to September 30 of the following year, except for the initial prospective rate year, which is between March 1, 1993, and September 30, 1994.
27. "Rebasing" means the process by which new Medicare Cost Report data, AHCCCS claim, and encounter data are collected and analyzed to reset periodically the inpatient hospital tiered per diem rates or the outpatient hospital cost-to-charge ratios.
28. "Reinsurance" means a risk-sharing program provided by the Administration to contractors for the reimbursement of certain contract service costs incurred by a member or eligible person beyond a certain monetary threshold.
29. "SDAD" means same day admit and discharge, which is a hospital stay with the admit and discharge occurring on the same calendar day.
30. "Tier" means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure or revenue codes, peer group, or NICU classification level, or any combination of these items.
31. "Tiered per diem" means a payment structure in which payment is made on a per-day basis depending upon the tier into which an AHCCCS inpatient hospital day of care is assigned.
32. "Total inpatient hospital days" means the total number of days, including all hospital subprovider and nursery days, from the Medicare Cost Report for all payors. Observation days and swing bed days are not included.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4).

R9-22-108. Grievance and Appeal Process Related Definitions
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "AHCCCS hearing officer" means a person designated by the Director to preside over administrative hearings regarding eligibility appeals and grievances.
2. "Appeal" means a review process initiated in accordance with Article 8.
3. "Grievance" means a complaint initiated in accordance with Article 8.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4).

R9-22-109. Quality Management and Analysis Related Definitions
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning: "Certification error" has the meaning in A.R.S. § 36-2905.01.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4).

R9-22-110. 1st- and 3rd-Party Liability Related Definitions
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "1st-party liability" means the resources available from any insurance or other coverage obtained directly or indirectly by a member or eligible person that provides benefits directly to the member or eligible person and is liable to pay all or part of the expenses for medical services incurred by the Administration, a contractor, a member, or an eligible person.
2. "3rd party" means an individual, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant, eligible person, or member.
3. "3rd-party liability" means the resources available from an individual, entity, or program that is or may be, by agreement, circumstance, or otherwise, liable to pay all or part of the medical expenses incurred by an applicant, eligible person, or member.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4).

R9-22-111. Reserved

R9-22-112. Behavioral Health Services Related Definitions
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning: "Acute mental health services" means inpatient or outpatient health services provided to treat mental or emotional disorders, as necessary for crisis stabilization, evaluation, and determination of future service needs.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4).

R9-22-113. Reserved

R9-22-114. Title IV-A Related Definitions
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "210" means 42 CFR 435.210.
2. "1931" means Section 1931 of the Social Security Act.
3. "Act" means the Social Security Act.
4. "Adequate notice" means a notice that explains the action the Department intends to take, the reason for the action, the specific authority for the action, the recipient's appeal rights, right to medical assistance pending appeal, and that is mailed before the effective date of the action.
5. "Administration" means the AHCCCS Administration.

6. "Adverse action" means an action taken by the Department to deny, discontinue, or reduce medical assistance.
7. "Appellant" means an applicant or recipient of medical assistance who is appealing an adverse action by the Department.
8. "Assistance unit" means a group of persons whose needs, income, and resources are considered as a unit for purposes of determining eligibility for medical assistance.
9. "Authorized representative" means a person who is authorized by the applicant, recipient, or legally responsible person to act on behalf of the applicant or recipient.
10. "Baby Arizona" means the public/private partnership program that provides a pregnant woman an opportunity to apply for medical assistance at a Baby Arizona provider's office through a streamlined eligibility process.
11. "BHS" means Behavioral Health Services, Arizona Department of Health Services.
12. "Bona fide funeral agreement" means a prepaid plan that specifically covers only funeral-related expenses as evidenced by a written contract.
13. "Burial plot" means a space reserved in a cemetery, crypt, vault, or mausoleum for the remains of a deceased person.
14. "Caretaker relative" means a parent or relative who maintains a family setting for a dependent child and who exercises responsibility for the day-to-day physical care, guidance, and support of that child.
15. "Cash assistance" means a program administered by the Department that provides assistance to needy families with dependent children under 42 U.S.C. 601 et seq.
16. "Child welfare agency" means any agency or institution defined in A.R.S. § 8-501(A)(1).
17. "CRS" means Children Rehabilitation Services.
18. "DCSE" means the Division of Child Support Enforcement, which is the division within the Department that administers the Title IV-D program and includes a contract agent operating a child support enforcement program on behalf of the Department.
19. "Department" means the Arizona Department of Economic Security.
20. "Dependent child" means a child defined at A.R.S. § 46-101(7).
21. "District Medical Consultant" means a licensed physician whom the Department employs to review medical records for the purpose of determining physical or mental incapacity.
22. "Eligibility determination date" means the date the Department makes the decision described in R9-22-1414 and issues the eligibility decision notice.
23. "FAA" or "Family Assistance Administration" means the administration within the Department's Division of Benefits and Medical Eligibility with responsibility for providing cash and food stamp assistance to an eligible person and for determining eligibility for medical assistance.
24. "Foster care maintenance payment" means a monetary amount defined in Section 475(4)(A) of the Social Security Act.
25. "Foster child" means a child placed in a foster care setting.
26. "FPL" means the federal poverty level guidelines published annually by the United States Department of Health and Human Services.
27. "Homebound" means a person who is confined to the home because of physical or mental incapacity.
28. "Income" means earned and unearned income combined.
29. "JTPA" or "Job Training Partnership Act" means the program authorized by 29 U.S.C. 1501 et seq. which prepares youth and unskilled adults for entry into the labor force and affords special job training.
30. "Liquid assets" means cash or another financial instrument that is readily convertible to cash.
31. "Mailing date", when used in reference to a document sent 1st class, postage prepaid, through the United States mail, means the date:
    a. Shown on the postmark;
    b. Shown on the postage meter mark of the envelope, if there is no postmark; or
    c. Entered on the document as the date of its completion, if there is no legible postmark or postage meter mark.
32. "Medical support" means an obligation of a natural or adoptive parent to provide health care coverage in the form of health insurance or court-ordered payment for medical care.
33. "Minor parent" means a person meeting the age requirements of R9-22-1401(B)(1) who is also a parent.
34. "Nonparent caretaker relative" means a person, other than a parent, who is related by blood, marriage, or lawful adoption to the dependent child and who maintains a family setting for the dependent child and exercises responsibility for the day to day care of the dependent child.
35. "Pre-enrollment process" means the process that provides an applicant the opportunity to choose an AHCCCS health plan before the determination of eligibility is completed.
36. "Recipient" means a person who is approved for and receiving medical assistance under this Article.
37. "Resources" means real and personal property including liquid assets.
38. "Review" means a review of all factors affecting an assistance unit's eligibility.
39. "Specified relative" means a person defined in R9-22-1418(B).
40. "Spendthrift restriction" means a legal restriction on the use of a resource that prevents a payer or beneficiary from alienating the resource.
41. "SVES" or "State Verification and Exchange System" means a system through which the Department exchanges income and benefit information with the Internal Revenue Service, Social Security Administration, State Wage, and Unemployment Insurance Benefit data files.
42. "Title IV-A" means the relevant provisions, specified in Section 1931 of the Social Security Act, of the Aid to Families With Dependent Children program that was in place in the state's Title IV-A State Plan as of July 1996.
43. "Title IV-D" of the Social Security Act means 42 U.S.C. 651-669, the statutes establishing the child support enforcement and establishment of paternity program.
44. "Title IV-E" of the Social Security Act means 42 U.S.C. 670-679, the statutes establishing the foster care and adoption assistance programs.
45. "TMA" means Transitional Medical Assistance.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-115. SSI MAO Related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "Aged" means a person who is 65 years of age or older, specified in 42 U.S.C. 1382c(a)(1)(A).
2. "Blind" means a person who has been determined blind by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(2).
3. "Certification period" means the period of time, not to exceed 6 months, during which a person who is eligible for FESP is anticipated to require emergency services.
4. "Disabled" means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E).

Historical Note
Final Section adopted at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-116. State-Only Eligibility Related Definitions
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "1-time income" means income that a person may receive only once. Examples are:
   a. The total of gifts received during the 3-month income period for a birthday, wedding, anniversary, graduation, religious event, or birth;
   b. The total of single payment death benefits; or
   c. The total of single payment insurance or legal settlements resulting from 1 accident.
2. "3-month income period" means the 91 or 92 days immediately preceding the application date. The 3-month income period is 92 days only if:
   a. A household member regularly receives a monthly or 2-times-a-month payment, and
   b. The household member received the 3rd of 3 monthly payments on the 92nd day preceding the application date, or
   c. The household member received the 6th of 6 2-times-a-month payments on the 92nd day preceding the application date.
3. "Certification period" means the period of time for which a person is certified under A.R.S. § 36-2901(4)(a), (c), (h), and (j) as eligible for AHCCCS benefits.
4. "Countable income" means gross income, less amounts that are disregarded under R9-22-1626(D) and amounts that are deducted under R9-22-1626(E).
5. "County eligibility staff" means a county employee designated to conduct eligibility interviews and determinations for AHCCCS or conduct related business.
6. "Date of determination" means the date on which a decision of an applicant's eligibility or ineligibility as a medically indigent, medically needy person, eligible low-income child, or state emergency services person is communicated by the county to the applicant by a Notice of Action and, for eligible applicants, to the Administration as specified in R9-22-1618.
7. "Date of discontinuance" means the last day of MI/MN, ELIC, SESP, or EAC coverage when there is a discontinuance.
8. "Deductible medical expense" means the cost of:
   a. A medically necessary service or supply that would be covered if provided to an AHCCCS member of any age under Articles 2 and 12;
   b. A medically necessary service or supply that would be covered if provided to an ALTCS member under 9 A.A.C. 28, Articles 2 and 11;
   c. Other medically necessary services that are provided by a licensed practitioner or physician;
   d. Assistance with daily living provided under prescription by a licensed physician or practitioner except when provided by the spouse of a patient or the parent of a minor patient;
   e. Care in a licensed nursing home, supervisory care facility, adult foster home, or in another residential care facility licensed by the Arizona Department of Health Services;
   f. Purchasing and maintaining a dog guide or service dog for the assistance of the applicant or member; or
   g. Health insurance premiums if the insured is a household member.
9. "Deemed application date" means the 30th day following either the original application date or a previously deemed application date, whichever is later.
10. "Dependent child" means an unborn child, an unemancipated minor, or an 18-year-old, if all of the following 3 conditions exist:
    a. The 18-year-old is a full-time student in a secondary school, or in a vocational, technical, or trade school that grant credits to be applied toward secondary school graduation;
    b. The 18-year-old is reasonably expected to graduate before reaching age 19; and
    c. The 18-year-old resides with 1 or both parents or a specified relative.
11. "Determination" means the process by which an applicant is approved or denied for coverage as an indigent or medically needy person, an eligible low-income child, or a state emergency services applicant.
12. "Discontinuance" means an action taken by county eligibility staff or the Administration to terminate a person's eligibility under MI/MN, ELIC, or SESP.
13. "Earned income" means money or its equivalent received by a household member in exchange for:
    a. Labor;
    b. Professional service or entrepreneurship, including income from the rental of real or personal property;
    c. Vacation pay;
    d. Sick pay;
    e. Tips; and
    f. Gratuities.
14. "Educational income" means income received as a scholarship or grant by a student for the purpose of paying tuition, fees, and related expenses, excluding room and board expenses.
15. "Emancipated minor" means a minor who is married or divorced, in military service, or the subject of a court order declaring the minor to be emancipated.
16. "Expressly emancipated minor" means a minor whose parent has or parents have signed a notarized affidavit indicating that the minor is no longer under parental support and control, and that the parent has or parents have surrendered claim to the state and federal tax dependency deductions provided that the minor is not living with a parent or a specified relative who is the legal guardian or acting as guardian, and a court has not ordered custody with another person or agency.
17. "Guardian" means a guardian, conservator, executor, or public fiduciary appointed by a court or other protective order to manage the affairs of a minor or incapacitated person.
18. "Head-of-household" means the family household member who assumes the responsibility for providing AHC-

CCS eligibility information for the family household members under Article 16.

19. "Hospitalized" means in a hospital as an inpatient at the time of application or at any time from the application date through the date of determination.
20. "Income" means money or other liquid resource that:
    a. Is received or deemed received by a person under R9-22-1626(C);
    b. Becomes available for a person's legal unrestricted use;
    c. Is used by a person; or
    d. Is due to a person but paid to someone else on the person's behalf, including monies paid from a trust to which the person is a beneficiary if the trust is excluded as a resource.
21. "Income-in-kind" means any noncash item or service received that is not deducted from other income to which the recipient is entitled.
22. "Interim change" means either a change occurring after the application date and before the eligibility decision or a change occurring during the certification period.
23. "Liquid assets" means all property and resources readily convertible to cash.
24. "Liquid resources" means liquid assets.
25. "Lump-sum income" means income received in a single payment instead of regularly occurring installments over a period of time.
26. "Month of determination" means the calendar month during which the date of determination occurs.
27. "Nonliquid resources" means all resources that are not readily convertible to cash.
28. "Proposal of discontinuance" means a notice sent to a person informing the person that AHCCCS benefits will terminate on a specified date unless the person provides proof of eligibility within 15 days following the date of the notice.
29. "Public assistance" means benefits provided to a person, either directly or indirectly by a city, county, state, federal, or governmental agency, based on financial needs.
30. "Redetermination" means the process by which an eligible person under A.R.S. §§ 36-2901.4(a), (c), or (h) applies for a new eligibility certification period before expiration of the current certification period.
31. "Resources" means property of any kind, real or personal, that can be converted to food, clothing, shelter, medical care, or money.
32. "Specified relative" means a nonparent caretaker of a dependent child who is a grandmother, grandfather, sister, brother, stepmother, stepfather, stepbrother, stepsister, aunt, uncle, 1st cousin, niece, nephew, or person of preceding generations whose relationship to the child is described by any of these terms preceded by a single "great" or "grand". A specified relative shall be at least 18 years old to apply on behalf of a dependent child, unless a court has awarded custody of the dependent child to the specified relative.
33. "Unearned income" means all income defined in subsection (20) except income which is defined as earned income in subsection (11).

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-117. Enrollment Related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "AEC" means annual enrollment choice.
2. "Annual enrollment choice" means the annual opportunity for a person to change contractors.
3. "Auto-assignment algorithm" means the mathematical formula used by the Administration to assign persons to the various contractors.
4. "CMDP" means Comprehensive Medical and Dental Services.
5. "Date of enrollment action" means the date the Administration processes an enrollment action on a person's enrollment record.
6. "Disenrollment" means the discontinuance of a person's entitlement to receive covered services from a contractor of record.
7. "Enrollment" means the process by which an eligible person becomes a member of a contractor's plan.
8. "IHS" means Indian Health Services.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

ARTICLE 2. SCOPE OF SERVICES

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. This Section was subsequently repealed and a new Section adopted under the regular rulemaking process.

R9-22-201. General Requirements

A. In addition to requirements and limitations specified in this Chapter, the following general requirements apply:
1. Covered services provided to a member shall be medically necessary and provided by, or under the direction of, a primary care provider or a dentist; specialist services shall be provided under referral from, and in consultation with, the primary care provider.
    a. The role or responsibility of a primary care provider, as defined in these rules, shall not be diminished, by the primary care provider delegating the provision of primary care for a member to a practitioner.
    b. Behavioral health screening and evaluation services may be provided, without referral from a primary care provider. Behavioral health treatment services shall be provided only under referral from and in consultation with the PCP, or upon authorization by the contractor or its designee.
    c. The contractor may waive the referral requirements.
2. Covered services provided to an eligible person through the AHCCCS Administration shall be medically necessary and provided by, or under the direction of, an attending physician, practitioner, or dentist;
3. Services shall be rendered in accordance with state and federal laws and regulations, the *Arizona Administrative Code* and AHCCCS contractual requirements;
4. Only emergency medical services provided in compliance with this Chapter shall be covered for a noncategori-

cally eligible person for 48 hours prior to enrollment in the system;

5. Experimental services as determined by the director, or services provided primarily for the purpose of research, shall not be covered;
6. AHCCCS services shall be limited to those services that are not covered for a member or eligible person who is a Medicare beneficiary;
7. Services or items, if furnished gratuitously, are not covered and payment shall be denied;
8. Personal care items are not covered and payment shall be denied;
9. Medical or behavioral health services shall not be covered if provided to:
   a. An inmate of a prison;
   b. A person who is in residence at an institution for the treatment of tuberculosis; or
   c. A person who is in an institution for the treatment of mental disorders, unless provided according to Article 12.

B. Services shall be provided by AHCCCS registered personnel or facilities that meet state and federal requirements, and are appropriately licensed or certified to provide the services.

C. Payment for services or items requiring prior authorization may be denied if prior authorization by the Administration or contractor is not obtained. Services provided during the prior period coverage do not require authorization. Emergency services under A.R.S. § 36-2908 do not require prior authorization.

1. For an eligible person, the AHCCCS Administration shall prior authorize services based on the diagnosis, complexity of procedures, and prognosis, and be commensurate with the diagnostic and treatment procedures requested by the eligible person's attending physician or practitioner.
2. Services for unrelated conditions, requiring additional diagnostic and treatment procedures, require additional prior authorization.
3. In addition to the requirements of Article 7, written documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.

D. Covered services rendered to a member shall be provided within the service area of the member's primary contractor except when:

1. A primary care provider refers a member out of the contractor's area for medical specialty care;
2. A covered service that is medically necessary for a member is not available within the contractor's service area;
3. A net savings in service delivery costs can be documented without requiring undue travel time or hardship for a member or the member's family;
4. A member is placed in a nursing facility located out of the contractor's service area;
5. Services provided are during the prior period coverage time frame authorized under Article 3; and
6. The service is otherwise authorized by the contractor based on medical practice patterns, and cost or scope of service considerations.

E. When a member is traveling or temporarily residing out of the service area of the member's contractor, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

F. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in these rules and in contract.

G. If a member or eligible person requests the provision of a service that is not covered by AHCCCS or not authorized by the contractor, the service may be rendered to the member or eligible person by an AHCCCS-registered service provider under the following conditions:

1. A document that lists the requested services and the itemized cost of each is prepared by the contractor and provided to the member or eligible person; and
2. The signature of the member or eligible person is obtained in advance of service provision indicating that the services have been explained to the member or eligible person, and that the member or eligible person accepts responsibility for payment.

H. The Director shall determine the circumstances under which an eligible person may receive services, other than emergency services, from service providers outside the eligible person's county of residence, or outside the state. Criteria considered by the Director in making this determination shall include availability and accessibility of appropriate care, and cost effectiveness.

I. If a member is referred out of the contractor's service area to receive an authorized medically necessary service for an extended period of time, the contractor shall also provide all other medically necessary covered services for the member during that time.

J. The restrictions, limitations, and exclusions in this Article shall not apply to the following groups:

1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27, and wishing to negotiate for extended benefits; and
2. Contractors electing to provide noncovered services.
   a. The costs associated with providing any noncovered service to a member shall not be included in development or negotiation of capitation.
   b. Noncovered services shall be paid from administrative revenue or other contractor funds, unrelated to Title XIX services.

K. In accordance with A.R.S. § 36-2907 the Director may, upon 30 days advance written notice to contractors and counties, modify the list of services for all members except those members categorically eligible according to Title XIX of the Social Security Act, as amended.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-201 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. The Section was subsequently amended through the exempt rulemaking process. The Section was then repealed through the regular rulemaking process.

R9-22-202. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-202 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Amended effective July 1, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1994, Ch. 322, § 21; filed with the Office of the Secretary of State June 22, 1995 (Supp. 95-3). Amended effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Section repealed effective September 22, 1997 (Supp. 97-3).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. The Section was subsequently repealed through the regular rulemaking process.

R9-22-203. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-203 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed effective September 22, 1997 (Supp. 97-3).

R9-22-204. Inpatient General Hospital Services

A. Inpatient services provided in a general hospital shall be covered by contractors or provided by fee-for-service providers or noncontracting providers and shall include:

1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
   a. Maternity care;
   b. Neonatal intensive care (NICU);
   c. Intensive care (ICU);
   d. Surgery;
   e. Nursery;
   f. Routine care; and
   g. Behavioral health (psychiatric) care.
      i. Emergency crisis behavioral health services may be provided for 3 days per acute episode and a maximum of 12 days per AHCCCS contract year for each member or eligible person unless services are provided under Article 12.
      ii. For purposes of this Section, the AHCCCS contract year shall be October 1 through September 30.
2. Ancillary services as specified by the Director and included in contract:
   a. Labor, delivery and recovery rooms, and birthing centers;
   b. Surgery and recovery rooms;
   c. Laboratory services;
   d. Radiological and medical imaging services;
   e. Anesthesiology services;
   f. Rehabilitation services;
   g. Pharmaceutical services and prescribed drugs;
   h. Respiratory therapy;
   i. Blood and blood derivatives;
   j. Central supply items, appliances, and equipment not ordinarily furnished to all patients and which are customarily reimbursed as ancillary services;
   k. Maternity services; and
   l. Nursery and related services.

B. The following limitations apply to general inpatient hospital services that are provided by fee-for-service providers and for which the Administration is financially responsible:

1. The cost of inpatient hospital accommodation for an eligible person shall be incorporated into the rate paid for the level of care as specified in subsection (A)(1).
2. Prior authorization shall be obtained from the Administration for the following inpatient hospital services provided to an eligible person:
   a. Nonemergency and elective admission, including psychiatric hospitalization, shall be authorized prior to the scheduled admission;
   b. Elective surgery, with the exception of voluntary sterilization procedures, shall be authorized prior to the surgery;
   c. An emergency hospitalization that exceeds 3 days or an intensive care unit admission that exceeds 1 day;
   d. Hospitalization beyond the number of days initially authorized shall be covered only if determined medically necessary through AHCCCS Administration concurrent team review;
   e. Services or items furnished to cosmetically reconstruct appearance after the onset of trauma or serious injury shall be authorized prior to service delivery; and
   f. Behavioral health services for an eligible person who is 18, 19, or 20 years of age that are provided on an emergency basis for crisis stabilization, and exceed 3 days per episode, or 12 days per contract year.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-204 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective December 22, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure

Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. The Section was subsequently repealed and a new Section adopted through the regular process.

R9-22-205. Physician and Primary Care Physician and Practitioner Services

A. Primary care provider services shall be furnished by a physician or practitioner and shall be covered for members when rendered within the provider's scope of practice under A.R.S. Title 32. An eligible person may receive these services through an attending physician or practitioner. Primary care provider services may be provided in an inpatient or outpatient setting and shall include at a minimum:
1. Periodic health examinations and assessments;
2. Evaluations and diagnostic workups;
3. Medically necessary treatment;
4. Prescriptions for medications and medically necessary supplies and equipment;
5. Referrals to specialists or other health care professionals when medically necessary;
6. Patient education;
7. Home visits when determined medically necessary;
8. Covered immunizations; and
9. Covered preventive health services.

B. The following limitations and exclusions apply to physician and practitioner services and primary care provider services:
1. Specialty care and other services provided to a member upon referral from a primary care provider or to an eligible person upon referral from the attending physician or practitioner shall be limited to the services or conditions for which the referral is made, or for which authorization is given, unless referral is waived by the Administration;
2. If a physical examination is performed with the primary intent to accomplish 1 or more of the objectives listed in subsection (A), it shall be covered by the member's contractor, or the Administration, except if there is an additional or alternative objective to satisfy the demands of an outside public or private agency. Alternative objectives may include physical examinations and resulting documentation for:
   a. Qualification for insurance;
   b. Pre-employment physical evaluation;
   c. Qualification for sports or physical exercise activities;
   d. Pilot's examination (FAA);
   e. Disability certification for establishing any kind of periodic payments;
   f. Evaluation for establishing 3rd-party liabilities; or
   g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection (A).
4. Orthognathic surgery shall be covered only for members and eligible persons who are less than 21 years of age;
5. The following services shall be excluded from AHCCCS coverage:
   a. Infertility services, reversal of surgically induced infertility (sterilization), and sex change operations;
   b. Abortion counseling services;
   c. Abortions, unless authorized under federal or state law;
   d. Services or items furnished solely for cosmetic purposes; and
   e. Hysterectomies unless determined to be medically necessary.
6. Prior authorization from the Administration shall be required for fee-for-service providers to render the following services to eligible persons:
   a. Elective or scheduled surgeries with the exception of voluntary sterilization procedures;
   b. Services or items provided to reconstruct or improve personal appearance after an illness or injury.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-205 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A), paragraph (15) and added paragraph (20) effective December 22, 1987 (Supp. 87-4). Amended subsection (C)(2) effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3).

Editor's Note: The following Section was renumbered and a new Section adopted under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not published as a proposed rule in the Arizona Administrative Register; the rule was not reviewed or approved by the Governor's Regulatory Review Council; and the agency was not required to hold public hearings on the rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-206. Organ and Tissue Transplantation Services

A. The following organ and tissue transplantation services shall be covered for a member or eligible person as specified in A.R.S. § 36-2907 if prior authorized and coordinated with the member's contractor, or the Administration for eligible persons:
1. Kidney transplantation;
2. Cornea transplantation;
3. Heart transplantation;
4. Liver transplantation;
5. Autologous and allogeneic bone marrow transplantation;
6. Lung transplantation;
7. Heart-lung transplantation;
8. Other organ transplantation if the transplantation is required by federal law for a categorically eligible person or member less than the age of 21 years and if other statutory criteria are met; and
9. Immunosuppressant medications, chemotherapy, and other related services.

B. The following limitations shall apply to organ and tissue transplantation services:
1. Artificial or mechanical hearts and xenografts are not covered services.
2. Organ or tissue transplantation services specified in subsection (A) are covered for a member or eligible person who is medically indigent or medically needy or for eligible assistance children and eligible low-income children only if funding is available as specified in A.R.S. § 36-2907;
3. Organ and tissue transplantation services are not covered during the fee-for-service emergency services only period for a member or eligible person who is medically indigent

or medically needy or for eligible assistance children and eligible low-income children, except for persons eligible for services under Laws 1995, 3rd Special Session, Ch. 1, § 5; and

4. Organ and tissue transplantation services are not covered under the state and federal emergency services programs.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-206 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-206 renumbered to R9-22-218, new Section R9-22-206 adopted effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Amended effective September 22, 1997 (Supp. 97-3).

R9-22-207. Dental Services

A. Emergency dental care, which encompasses the following services, shall be covered:

1. Emergency oral diagnostic examination including laboratory and radiographs when necessary to determine an emergent condition;
2. Immediate palliative treatment, including extractions when professionally indicated, for relief of severe pain associated with an oral or maxillofacial condition;
3. Initial treatment for acute infection;
4. Immediate and palliative procedures for acute craniomandibular problems and for traumatic injuries to teeth, bone, or soft tissue;
5. Preoperative procedures; and
6. Anesthesia appropriate for optimal patient management.

B. The following limitations shall apply to emergency dental services provided by the Administration's fee-for-service providers:

1. Treatment for the prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection. Root canals are limited to treatment for acute infection or to eliminate pain;
2. Routine restorative procedures and routine root canal therapy are not emergency services;
3. Radiographs are limited to symptomatic teeth for use as a diagnostic tool preceding treatment and to support the need for, and provision of, dentures;
4. Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxillae and mandible; and
5. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.

C. Covered denture services include medically necessary dental services and procedures associated with, and including, the provision of dentures.

D. The following limitations shall apply to dentures provided by the Administration's fee-for-service providers:

1. Provision of dentures for cosmetic purposes is not a covered service;
2. Extractions of asymptomatic teeth are not covered unless their removal constitutes the most cost effective dental procedure for the provision of dentures;
3. Radiographs are limited to use as a diagnostic tool preceding treatment of symptomatic teeth and to support the need for, and provision of, dentures; and
4. Prior authorization of dental services for an eligible person is required from the Administration for the following:
   a. Provision of medically necessary dentures;
   b. Replacement, repair, or adjustment to dentures; and
   c. Provision of obturators or other prosthetic appliances for restoration or rehabilitation.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-207 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-207 repealed, new Section R9-22-207 adopted effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3).

R9-22-208. Laboratory, Radiology, and Medical Imaging Services

Laboratory, radiology, and medical imaging services shall be covered services if:

1. Prescribed for members by a primary care provider or a dentist, or if prescribed by a physician or practitioner upon referral from the primary care provider or dentist, unless referral is waived by the Administration;
2. Provided for an eligible person by a fee-for-service provider and the services are prescribed by the attending physician, practitioner, or dentist of the eligible person;
3. Provided in hospitals, clinics, physician offices, or other health care facilities by licensed health care providers; and
4. Provided by a provider that meets all applicable state and federal license and certification requirements and provides only services that are within the scope of practice stated in the provider's license or certification.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-208 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-208 repealed, new Section R9-22-208 adopted effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. The Section was subsequently repealed and new Section adopted through the regular process.

R9-22-209. Pharmaceutical Services

A. Pharmaceutical services may be provided by an inpatient or outpatient provider including hospitals, clinics, or appropriately licensed health care facilities and pharmacies.

B. The Administration or its contractor shall make pharmaceutical services available during customary business hours and shall be located within reasonable travel distance of a member's residence.

C. Pharmaceutical services shall be covered if prescribed for a member by the member's primary care provider or dentist, or if prescribed by a specialist upon referral from the primary care provider unless referral is waived by the Administration or upon authorization by the contractor or its designee. Pharmaceutical services provided for an eligible person shall be covered if prescribed by the attending physician, practitioner, or dentist.

D. The following limitations shall apply to pharmaceutical services:
1. A medication personally dispensed by a physician or dentist is not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
2. A prescription in excess of a 30 day supply or a 100-unit dose is not covered unless:
   a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is more.
   b. The member or eligible person will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 days or 100-unit dose, whichever is more.
3. A nonprescription medication is not covered unless an appropriate, alternative over-the-counter medication is available and less costly than a prescription medication.
4. A prescription is not covered if filled or refilled in excess of the number specified, or if an initial prescription or refill as dispensed after 1 year from the original prescribed order.
5. Approval by the authorized prescriber is required for all changes in, or additions to, an original prescription. The date of a prescription change is to be clearly indicated and initialed by the dispensing pharmacist.

E. A contractor shall monitor and take necessary actions to ensure that a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being, is provided sufficient services to eliminate any gap in the required pharmaceutical regimen.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-209 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective September 24, 1986 (Supp. 86-5). Amended subsections (A) and (C) effective December 22, 1987 (Supp. 87-4). Amended subsection (C)(3), effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3).

R9-22-210. Emergency Medical and Behavioral Health Services

A. Provision of and payment for emergency services. An emergency medical service and a behavioral health emergency or crisis stabilization service shall be provided based on the prudent layperson standard to a member or an eligible person by a licensed provider, registered with AHCCCS to provide the services. Emergency services and stabilization services shall be provided for and paid for as specified in 42 CFR 438.114 as of September 29, 1998, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. Verification. A provider of emergency services shall verify eligibility and enrollment status through the Administration to determine the need for notification to a contractor for a member, or the Administration for an eligible person, and to determine the party responsible for payment of services rendered.

C. Access. Access to an emergency room and emergency medical and behavioral health services shall be available 24 hours per day, 7 days per week in each contractor's service area. The use of an examining or a treatment room shall be available when required by a physician or a practitioner for the provision of emergency services.

D. Consultation. Consultation provided by a psychiatrist or a psychologist shall be covered as an emergency service if required to evaluate or stabilize an acute episode of mental illness or substance abuse.

E. Prior authorization. An emergency service does not require prior authorization but a provider shall comply with the following notification requirements:
1. A provider, a nonprovider, and a noncontracting provider furnishing emergency services to a member shall notify a member's contractor within 12 hours from the time a member presents for services;
2. A provider of emergency services for an eligible person is not required to notify the Administration; and
3. If a member's medical condition is determined not to be an emergency medical condition, as defined in Article 1 of this Chapter, a provider shall notify a member's contractor before initiation of treatment and follow the prior authorization requirements and protocol of a contractor regarding treatment of a member's nonemergent condition. Failure to provide timely notice or comply with prior authorization requirements of a contractor constitutes cause for denial of payment.

F. Post-stabilization services. After a member's emergent condition has been stabilized, a provider, a nonprovider, and a noncontracting provider shall request authorization from a contractor for post-stabilization services. A contractor shall pay for the post-stabilization services if:
1. The service is prior authorized by a contractor; or
2. A contractor does not respond to an authorization request within the time-frame specified in 42 CFR 438.114, as of September 29, 1998, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-210 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-210 repealed, new Section R9-22-210 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (1) effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 867, effective

March 4, 1999 (Supp. 99-1).

R9-22-211. Transportation Services

A. Emergency ambulance services.
1. Emergency ambulance transportation shall be a covered service for a member or eligible person. Payment shall be limited to the cost of transporting the member or eligible person in a ground or air ambulance:
   a. To the nearest appropriate provider or medical facility capable of meeting the member's or eligible person's medical needs; and
   b. When no other means of transportation is both appropriate and available.
2. A ground or air ambulance transport that originates in response to a 911 call or other emergency response system shall be reimbursed by the member's contractor, or the Administration for eligible persons, if the medical condition at the time of transport justified a medically necessary ambulance transport. No prior authorization is required for reimbursement of these transports.
3. Determination of whether transport is medically necessary shall be based upon the medical condition of the member or eligible person at the time of transport.
4. A ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure to notify the contractor may constitute cause for denial of claims.
5. Notification to the Administration of emergency transportation provided to an eligible person is not required, but the provider shall submit documentation with the claim which justifies the service.

B. Medically necessary nonemergency transportation.
1. As specified in contract, contractors shall arrange or provide medically necessary nonemergency transportation services for a member who is unable to arrange or pay for the member's own transportation to a service site or location if free transportation services are not available.
2. If an eligible person requires medically necessary nonemergency transportation due to an inability to arrange or pay for the services, or the services are not available at no cost, the attending physician or practitioner shall order those services.

C. Air ambulance services shall be covered only if:
1. The air ambulance transport is initiated upon the request of an emergency response unit, a law enforcement official, a hospital or clinic medical staff member, a physician, or a practitioner;
2. The point of pickup is inaccessible by ground ambulance, or great distances, or other obstacles are involved in getting emergency services to the member or eligible person or transporting the member or eligible person to the nearest hospital or other provider with appropriate facilities; and
3. The medical condition of the member or eligible person requires timely ambulance service and ground ambulance service will not suffice.

D. Meals, lodging, and escort services.
1. Expenses for meals, lodging, and transportation for a member or eligible person while en route to, or returning from, an approved and prior authorized health care service site out of the member's or eligible person's service area or county of residence shall be an AHCCCS covered service.
2. Meals, lodging, and transportation expenses of an escort, who may be a family household member accompanying an eligible person or member out of the eligible person's or member's service area, shall be covered if the services of the escort are ordered in writing by the member's primary care provider or the eligible person's attending physician or practitioner. A salary for an escort shall be covered if the escort is not a part of the eligible person's or member's family household.

E. Limitations.
1. Family, household members, friends, and neighbors shall be reimbursed for providing transportation services only if:
   a. The services are ordered in writing by the member's PCP or the eligible person's attending physician or practitioner; or
   b. The services are authorized by the member's contractor or designee; and
   c. Appropriate free transportation or public transportation is not available.
2. A charitable organization routinely providing transportation services at no cost to ambulatory or chairbound persons shall not charge or seek reimbursement from the Administration or contractors for the provision of these services to a member or eligible person but may enter into subcontractual agreements with AHCCCS contractors for medically necessary transportation services provided to their members.
3. Payment for meals, lodging, and transportation of an escort and a salary not to exceed the federal minimum wage shall be allowed only when the member or eligible person requires covered services that are not available in the service area. If the member or eligible person is admitted to an inpatient facility, meals, lodging, and a salary for the escort shall be covered only when accompanying the member or eligible person en route to, and returning from, the inpatient facility.

F. Subject to A.R.S. § 36-2908(E) prior authorization from the Administration for transportation services provided for eligible persons is required for the following:
1. Medically necessary nonemergency transportation services not originated through a 911 call; and
2. All meals, lodging, and services of an escort accompanying the eligible person under subsection (D)(2).

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-211 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3).

R9-22-212. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices

A. Medical supplies, durable equipment, and orthotic and prosthetic devices shall be covered services if:
1. Prescribed for a member by the member's primary care provider or if prescribed by a physician or practitioner upon referral from the primary care provider unless referral is waived by the Administration; or
2. Prescribed by the attending physician or practitioner of an eligible person; and
3. Provided in compliance with requirements of this Chapter.

B. Medical supplies include consumable items covered under Medicare that are provided to a member or eligible person and that are not reusable.

C. Medical equipment includes any durable item, appliance, or piece of equipment that is designed for a medical purpose, is generally reusable by others, and is purchased or rented for a member or eligible person.

D. Prosthetic and orthotic devices include only those items that are essential for the habilitation or rehabilitation of a member or eligible person.

E. Prescriptive lenses are covered if they are the sole prosthetic device after a cataract extraction;

F. The following limitations apply:
1. If medical equipment can not be reasonably obtained from alternative resources at no cost, the medical equipment shall be furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the equipment shall not exceed the cost of the equipment if purchased.
2. Reasonable repair or adjustment of purchased medical equipment shall be covered if necessary to make the equipment serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.
3. Changes in, or additions to, an original order for medical equipment shall be approved by the member's primary care provider or authorized prescriber, or prior authorized by the Administration for eligible persons, and shall be indicated clearly and initialed by the vendor. No change or addition to the original order for medical equipment may be made after a claim for services has been submitted to the member's contractor, or the Administration for eligible persons, without prior written notification of the change or addition.
4. Rental fees shall terminate:
   a. No later than the end of the month in which the primary care provider or authorized prescriber certifies that the member or eligible person no longer needs the medical equipment;
   b. When the member or eligible person is no longer eligible for AHCCCS services; or
   c. When the member is no longer enrolled with a contractor, with the exception of transitions of care as specified by the Director.
5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming shall not be covered unless needed to treat a medical condition and provided in accordance with a prescription.
6. First aid supplies shall not be covered unless they are provided in accordance with a prescription.
7. Hearing aids and prescriptive lenses shall not be covered for members or eligible persons who are 21 years of age and older, unless authorized under subsection (E).

G. Fee-for-service providers shall obtain prior authorization from the Administration before providing:
1. Consumable medical supplies exceeding $50.00 per month; or
2. Durable medical equipment or prosthetic or orthotic devices for an eligible person for all rentals or if the cost to purchase the equipment or device exceeds $200.00.

H. Liability and ownership.
1. Purchased durable medical equipment provided to members but which is no longer needed may be disposed of in accordance with each contractor's policy.
2. The state shall retain title to purchased durable medical equipment supplied to eligible persons who become ineligible or no longer require its use.
3. If customized durable medical equipment is purchased by the Administration for an eligible person, or for a member by the contractor, the equipment will remain with the person during times of transition, or upon loss of eligibility.
   a. For purposes of this Section, customized durable medical equipment refers to equipment that has been altered or built to specifications unique to a member's or eligible person's medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.
   b. Customized equipment obtained fraudulently by a member or an eligible person shall be returned for disposal to the member's contractor, or to the Administration if the customized equipment was purchased for an eligible person.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-212 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-212 repealed, new Section R9-22-212 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (2), and deleted subsection (C) effective October 1, 1986 (Supp. 86-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3).

R9-22-213. Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)

A. The following EPSDT services shall be covered for a member or eligible person less than 21 years of age:
1. Screening services including:
   a. Comprehensive health and developmental history;
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations according to age and health history;
   d. Laboratory tests; and
   e. Health education, including anticipatory guidance;
2. Vision services including:
   a. Diagnosis and treatment for defects in vision;
   b. Eye examinations for the provision of prescriptive lenses; and
   c. Provision of prescriptive lenses;
3. Hearing services including:
   a. Diagnosis and treatment for defects in hearing;
   b. Testing to determine hearing impairment; and
   c. Provision of hearing aids;
4. Dental services including:
   a. Emergency dental services as specified in R9-22-207;
   b. Preventive services including screening, diagnosis, and treatment of dental disease; and
   c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
5. Orthognathic surgery;
6. Behavioral health services under Article 12;
7. Other necessary health care, diagnostic services, treatment and measures required by 42 U.S.C. § 1396d(r)(5), April 1, 1990, incorporated by reference and on file with the Administration and the Office of Secretary of State. This incorporation by reference contains no future editions or amendments.

B. All providers of EPSDT services shall meet the following standards:

1. Provide services by or under the direction of, the member's primary care provider or dentist, or the eligible person's attending physician, practitioner, or dentist.
2. Perform tests and examinations in accordance with the AHCCCS Administration Periodicity Schedule.
   a. Refer members and eligible persons as necessary for dental diagnosis and treatment, and necessary specialty care.
   b. Refer members and eligible persons as necessary for behavioral health evaluation and treatment services.

C. Contractors shall meet the following additional conditions for EPSDT members:
1. Provide information to members and their parents or guardians concerning EPSDT services;
2. Notify members and their parents or guardians regarding the initiation of EPSDT screening and subsequent appointments according to the AHCCCS Administration Periodicity Schedule; and
3. Offer and provide, if requested, necessary assistance with transportation to and from providers, in accordance with R9-22-211, and with scheduling appointments for services.

D. Members and eligible persons with special health care needs may be referred to the Children's Rehabilitative Service program.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-213 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-213 repealed, new Section R9-22-213 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3).

R9-22-214. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-214 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-214 repealed, new Section R9-22-214 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (4) and added subsection (C), paragraph (2) effective October 1, 1986 (Supp. 86-5). Correction to subsection (C), paragraph (2) (Supp. 87-4). Section repealed effective September 22, 1997 (Supp. 97-3).

R9-22-215. Other Medical Professional Services

A. The following medical professional services provided to a member by a contractor, or an eligible person through the Administration, shall be covered services when provided in an inpatient, outpatient, or office setting within limitations specified below:
1. Dialysis;
2. Family planning services, including medications, supplies, devices, and surgical procedures provided to delay or prevent pregnancy. Family planning services are limited to:
   a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
   b. Sterilization; and
   c. Natural family planning education or referral;
3. Certified nurse midwife services provided by a certified nurse practitioner in midwifery;
4. Licensed midwife service for prenatal care and home births in low risk pregnancies;
5. Podiatry services when ordered by a member's primary care provider or an eligible person's attending physician or practitioner;
6. Respiratory therapy;
7. Ambulatory and outpatient surgery facilities services;
8. Home health services under A.R.S. § 36-2907(D);
9. Private or special duty nursing services when medically necessary and prior authorized;
10. Rehabilitation services including physical therapy, occupational therapy, audiology and speech therapy within limitations in this Article;
11. Total parenteral nutrition services;
12. Chemotherapy; and
13. Consultation for acute episodes of mental illness or substance abuse provided by a psychiatrist or psychologist regarding evaluation, stabilization, and treatment plan determination, except consultation services provided under Article 12. Services shall be through a referral from a member's primary care provider, or an eligible person's attending physician or practitioner unless the requirement for referral is waived by the Administration.

B. Prior authorization from the Administration for eligible persons is required for services listed in subsections (A)(4) through (11).

C. The following shall be excluded as AHCCCS covered services:
1. Occupational and speech therapies provided on an outpatient basis for members and eligible persons 21 years of age and older;
2. Physical therapy provided only as a maintenance regimen;
3. Abortion counseling; or
4. Services or items furnished solely for cosmetic purposes.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-215 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3).

R9-22-216. Nursing Facility Services

A. Nursing facility services including room and board shall be covered for a maximum of 90 days per contract year if the medical condition of a member or eligible person is such that, if nursing facility services are not provided, hospitalization of the individual would result.

B. Except as otherwise provided in 9 A.A.C. 28, the following services shall be excluded for purpose of separate billing if provided in a nursing facility:
1. Nursing services including but not limited to:
   a. Administration of medication;
   b. Tube feedings;
   c. Personal care services (assistance with bathing and grooming);
   d. Routine testing of vital signs; and
   e. Maintenance of catheters;

2. Basic patient care equipment and sickroom supplies, including, but not limited to:
   a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over-the-counter remedies;
   b. Bathing and grooming supplies;
   c. Identification devices;
   d. Skin lotions;
   e. Medication cups;
   f. Alcohol wipes, cotton balls, and cotton rolls;
   g. Rubber gloves (non sterile);
   h. Laxatives;
   i. Beds and accessories;
   j. Thermometers;
   k. Ice bags;
   l. Rubber sheeting;
   m. Passive restraints;
   n. Glycerin swabs;
   o. Facial tissue;
   p. Enemas;
   q. Heating pads;
   r. Diapers; and
   s. Alcoholic beverages;
3. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating;
4. Any services that are included in a nursing facility's room and board charge or services that are required of the nursing facility to meet federal mandates, state licensure standards, or county certification requirements;
5. Administrative physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
6. Physical therapy prescribed only as a maintenance regimen, and
7. Assistive devices and durable medical equipment.

C. Each admission shall be prior authorized by the Administration for eligible persons.

Historical Note
Adopted effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. This Section was subsequently repealed and a new Section adopted under the regular rulemaking process.

R9-22-217. Services Included in the State and Federal Emergency Services Programs

A. Covered state and federal emergency services to treat an emergency medical condition shall include the following, within limitations specified in this Article:
1. Inpatient general hospital services;
2. Physician services;
3. Emergency dental services;
4. Ancillary services, such as laboratory, radiology, and medical imaging services;
5. Pharmaceutical services;
6. Emergency medical services;
7. Emergency transportation services; and
8. Medical supplies, durable medical equipment subject to the limitations described in subsection (C)(1)(d), and medications.

B. Prenatal care services. In addition to emergency services listed in subsection (A), prenatal care shall be provided for persons identified in A.R.S. § 36-2905.05(B).

C. Limitations and exclusions.
1. The following limitations shall apply:
   a. Covered services are limited to services that are medically necessary to treat an emergency medical condition.
   b. Emergency behavioral health services are limited to emergency services that are medically necessary for crisis stabilization, not to exceed 3 days per episode or for a maximum of 12 days per year.
   c. The continuance of inpatient or outpatient emergency care subsequent to the initial treatment of the emergency medical condition, is not to exceed the acute level of care that is medically necessary.
   d. Durable medical equipment is limited to equipment that is medically necessary and cost effective at the time of discharge.
2. The following exclusions shall apply:
   a. All services deemed nonemergent by the Administration;
   b. Private duty nursing;
   c. Elective surgery;
   d. Physical, speech, or occupational therapy;
   e. Prevention programs;
   f. Acute rehabilitation services provided in a licensed general hospital rehabilitation unit or rehabilitation specialty center, if the primary purpose of the hospitalization is for rehabilitation;
   g. Nonemergency transportation services;
   h. Hearing aids, prescriptive lenses, or dentures;
   i. Family planning services;
   j. All services provided after the person's Arizona residency has terminated and all services provided outside the boundaries of the United States;
   k. All organ and tissue transplantation and related services; and
   l. Long term care services.

D. Prior authorization of federal and state emergency services.
1. With the exception of emergency room services, emergency transportation services, and emergency dental services, all services listed under subsection (A) require prior authorization from the Administration.
2. Failure to obtain prior authorization constitutes cause for denial of payment by the Administration.

E. All service requirements, exclusions, and limitations specified in this Article shall apply to services provided through the federal or state emergency services program.

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3).

Editor's Note: The following Section was renumbered under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not published as a proposed rule in the Arizona Administrative Register; the rule was not reviewed or approved by the Governor's Regulatory Review

Council; and the agency was not required to hold public hearings on the rule. This Section was subsequently repealed through the regular rulemaking process.

R9-22-218. Repealed

Historical Note

Section R9-22-218 renumbered from R9-22-206 effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Section repealed effective September 22, 1997 (Supp. 97-3).

ARTICLE 3. REPEALED

R9-22-301. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-301 renumbered together with former Section R9-22-102 as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). New Section R9-22-301 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (8), subsection (E), paragraph (3), and subsection (J), paragraph (5) effective October 1, 1986 (Supp. 86-5). Amended subsections (C) and (E) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B) and (C) effective October 1, 1987; amended subsection (D) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. The Section was subsequently repealed through the regular rulemaking process.

R9-22-302. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-302 repealed, new Section R9-22-302 adopted effective November 20, 1984 (Supp. 84-6). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-303. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-303 repealed, new Section R9-22-303 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-304. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-304 repealed, new Section R9-22-304 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-305. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-305 repealed, new Section R9-22-305 adopted effective November 20, 1984 (Supp. 84-6). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. The Section was subsequently repealed through the regular rulemaking process.

R9-22-306. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-306 repealed, new Section R9-22-306 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraphs (1) and (6) effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (1) and added a new subsection (N) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective October 1, 1987; amended subsection (N) effective December 22, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. The Section was subsequently repealed through the regular rulemaking process.

R9-22-307. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsections (A) and (C), added subsection (G) and (H) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-307 repealed, new Section R9-22-307 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) as an emergency effective December 4, 1985 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 85-6). Permanent amendment to subsection (A) effective February 5, 1986 (Supp. 86-1). Amended subsections (E) and (F) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. The Section was subsequently repealed through the regular rulemaking process.

R9-22-308. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended by adding subsection (C) effective March 2, 1984 (Supp. 84-2). Former Section R9-22-308 repealed, new Section R9-22-308 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. The Section was subsequently repealed through the regular rulemaking process.

R9-22-309. Repealed

Historical Note

Adopted effective August 30, 1984 (Supp. 82-4). Amended (D)(1)(d) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-309 repealed, new Section R9-22-309 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (F) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (A), (B) and (C) effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-310. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended (B)(7) and added subsections (C) and (D) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-310 repealed, new Section R9-22-310 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) and deleted subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (7) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. The Section was subsequently repealed through the regular rulemaking process.

R9-22-311. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-311 repealed, new Section R9-22-311 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit

notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. The Section was subsequently repealed through the regular rulemaking process.

R9-22-312. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsections (A) and (B), added subsection (D) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-312 repealed, new Section R9-22-312 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. This Section was subsequently amended through the regular rulemaking process. The Section was subsequently repealed through the regular rulemaking process.

R9-22-313. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended subsections (C) and (D) as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended subsections (D) and (E) as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-313 repealed, new Section R9-22-313 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsections (B), (C), (E) and (G) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B) and (C) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-314. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsection (A) and added subsection (F) as an emergency effective February 28, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended subsection (A) and added subsection (F) as a permanent rule effective May 16, 1983; text of the amended rule identical to the emergency (Supp. 83-3). Former Section R9-22-314 repealed, new Section R9-22-314 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. The Section was subsequently repealed through the regular rulemaking process.

R9-22-315. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-315 repealed, new Section R9-22-315 adopted effective November 20, 1984 (Supp. 84-6). Repealed effective October 1, 1985 (Supp. 85-5). New Section R9-22-315 adopted effective February 5, 1986 (Supp. 86-1). Amended effective February 26, 1988 (Supp. 88-1). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-316. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as an emergency effective February 9, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as a permanent rule effective May 16, 1983; text of permanent rule identical to the emergency (Supp. 83-3). Amended effective October 1, 1983 (Supp. 83-5). Correction subsection (A), paragraph (1) amended effective October 1, 1983, (Supp. 83-6). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-316 repealed, new Section R9-22-316 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective October 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective April 13, 1990 (Supp. 90-2). Section

repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-317. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-317 repealed, new Section R9-22-317 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1986 (Supp. 86-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. This Section was subsequently amended through the regular rulemaking process. The Section was subsequently repealed through the regular rulemaking process.

R9-22-318. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-318 repealed, new Section R9-22-318 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) and added subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective October 1, 1987; amended subsection (A) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective December 13, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-319. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-319 repealed, new Section R9-22-319 adopted effective November 20, 1984 (Supp. 84-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-320. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-320 repealed, new Section R9-22-320 adopted effective November 20, 1984 (Supp. 84-6). Amended effective April 13, 1990 (Supp. 90-2). Repealed effective December 13, 1993 (Supp. 93-4).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. This Section was subsequently amended through the regular rulemaking process. The Section was subsequently repealed through the regular rulemaking process.

R9-22-321. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-321 repealed, new Section R9-22-321 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (B) through (E) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987 (Supp. 87-4). Amended subsections (B) and (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-322. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective May 27, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-3). Former Section R9-22-322 repealed, new Section R9-22-322 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-322 repealed, new Section R9-22-322 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective September 29, 1992 (Supp. 92-3). Amended December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-323. Repealed

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-323 repealed, new Section R9-22-323 adopted effective October 1, 1983 (Supp. 83-5).

Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-323 repealed, new Section R9-22-323 adopted effective November 20, 1984 Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (B) through (D) effective October 1, 1986 (Supp. 86-5). Amended subsections (A), (B) and (D) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B), (D) and (E) effective October 1, 1987 (Supp. 87-4). Amended subsections (B) and (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-324. Repealed

Historical Note

Adopted as an emergency effective July 27, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-4). Former Section R9-22-324 adopted as an emergency renumbered as Section R9-22-327. New Section R9-22-324 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-324 repealed, former Section R9-22-323 renumbered as Section R9-22-324 and adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Former Section R9-22-324 repealed, new Section R9-22-324 adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-324 repealed, new Section R9-22-324 adopted effective November 20, 1984 (Supp. 84-6). Change in heading only effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-325. Repealed

Historical Note

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-325 repealed, new Section R9-22-325 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Sup. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-326. Repealed

Historical Note

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-326 repealed, new Section R9-22-326 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Change in heading only effective October 1, 1987 (Supp. 87-4). Amended subsection (A) effective May 30, 1989 (Supp. 89-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. The Section was subsequently repealed through the regular rulemaking process.

R9-22-327. Repealed

Historical Note

Former Section R9-22-324 adopted as an emergency effective July 27, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days renumbered as Section R9-22-327 and adopted as a permanent rule effective October 1, 1983 (Supp. 83-5). Former Section R9-22-327 repealed, new Section R9-22-327 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (A), (D), (E), (G), (H), and (I) effective October 1, 1986 (Supp. 86-5). Amended subsection (D) and added a new subsection (J) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (A) and (E) effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-328. Repealed

Historical Note

Adopted as an emergency effective October 6, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-5). Emergency Expired. New Section R9-22-328 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (A) and (E) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (D) effective October 1, 1987 (Supp. 87-4). Amended subsection (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-329. Repealed

Historical Note

Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. New Section R9-22-329 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-330. Repealed

Historical Note
Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. New Section R9-22-330 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended subsection (A) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-331. Repealed

Historical Note
Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-332. Repealed

Historical Note
Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1,1985 (Supp. 85-5). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. The Section was subsequently repealed through the regular rulemaking process.

R9-22-333. Repealed

Historical Note
Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-334. Repealed

Historical Note
Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-335. Repealed

Historical Note
Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-336. Repealed

Historical Note
Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective September 16, 1987 (Supp. 87-3). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-337. Repealed

Historical Note
Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Correction to subsection (B), paragraph (1) (Supp. 87-3). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-338. Repealed

Historical Note
Adopted effective November 20, 1984 (Supp. 84-6). Heading changed effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-339. Repealed

Historical Note
Adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective October 1, 1987 (Supp. 87-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-340. Repealed

Historical Note
Adopted effective October 1, 1986 (Supp. 86-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-341. Repealed

Historical Note
Adopted effective March 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-342. Repealed

Historical Note
Adopted effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. The Section was subsequently repealed through the regular rulemaking process.

R9-22-343. Repealed

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the agency was not required to hold public hearings on the rules. The Section was subsequently repealed through the regular rulemaking process.

R9-22-344. Repealed

Historical Note
Adopted under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

ARTICLE 4. CONTRACTS, ADMINISTRATION, AND STANDARDS

R9-22-401. General

A. A contract to provide services under AHCCCS shall be established between the Administration and a qualified provider of health care in conformance with the requirements in this Article. A contract and a subcontract entered into according to this Article is a public record and shall be on file with the Administration as specified in selected provisions of 42 and 45 CFR, as of October 1, 1995. These citations are incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. A contractor shall not knowingly have a director, an officer, a partner, or a person with ownership of more than 5% of a contractor's equity who has been debarred or suspended by any federal agency specified in 42 U.S.C. 1396u-2, as of August 5, 1997, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

C. The Administration shall certify a contractor as a risk-bearing entity as specified in A.R.S. § 36-2903, as specified in RFP and contract, and as specified in 42 U.S.C. 1396b(m), as of August 5, 1997, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

Historical Note
Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-401 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 31, 1997 (Supp. 97-1). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1).

R9-22-402. Contracts

A. Each contract between the Administration and a contractor shall be in writing and contain at least the following information:

1. The method and amount of compensation or other consideration to be received by the contractor.
2. The name and address of the contractor.
3. The population to be covered by the contract.
4. The amount, duration, and scope of medical services to be provided, or for which compensation will be paid.
5. The term of the contract, including the beginning and ending dates, as well as methods of extension, renegotiation, and termination.
6. A provision that the Director or the Secretary of the U.S. Department of Health and Human Services may evaluate, through inspection or other means, the quality, appropriateness, or timeliness of services performed under the contract.
7. A description of patient, medical, and cost record-keeping systems and a provision that the Director or the Secretary of the U.S. Department of Health and Human Services may audit and inspect any of the contractor's records that pertain to services performed and determinations of amounts payable under the contract. These records shall be maintained by the contractor for 5 years from the date of final payment or, for records relating to costs and expenses to which the Administration has taken exception, 5 years after the date of final disposition or resolution of the exception.
8. A provision to retain of a specified percentage of periodic payments to contractors, have a reserve fund, or use another means to adjust the payments made to contractors, based on utilization efficiency, including incentives for maintaining quality care and minimizing unnecessary inpatient services. This provision applies only to capped fee-for-service and AHCCCS-assembled network contractors and providers that participate in a risk retention fund in accordance with R9-22-714.
9. A provision that contractors maintain all forms, records, and statistical information required by the Director for purposes of audit and program management. This material, including files, correspondence, and related information pertaining to services rendered or claims for payments shall be subject to inspection and copying by the Administration and the U.S. Department of Health and Human Services during normal business hours at the place of business of the person or organization maintaining the records.
10. A provision that the contractor safeguard information.

11. Any activities to be performed by the contractor affecting categorically eligible persons and members that are related to third-party liability requirements prescribed in 42 CFR 433, Subpart D, as of October 1, 1995, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
12. Functions that may be subcontracted, including a provision that any subcontract meets the requirements of 42 CFR 434.6(b), as of October 1, 1995, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
13. A provision that the contractor arrange for the collection of any required co-payment.
14. A provision that the contractor will not bill or attempt to collect from a member for any covered service except as may be authorized by statute or these rules.
15. A provision that the contract will not be assigned or transferred without the prior approval of the Director.
16. Procedures for enrollment or re-enrollment of the covered population.
17. Procedures and criteria for terminating the contract.
18. A provision that any cost sharing requirements imposed for services furnished to members are in accordance with 42 CFR 447.50 through 447.58, as of October 1, 1995, which are incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
19. A provision that specifies the actuarial basis for computation of capitation fees.
20. Procedures for terminating enrollment and choice of health professional.
21. A provision that a contractor provide for an internal grievance procedure that:
    a. Is approved in writing by the Administration;
    b. Provides for prompt resolution; and
    c. Ensures the participation of individuals with authority to require corrective action.
22. A provision that the contractor maintain an internal quality-management-system consistent with AHCCCS rules.
23. A provision that the contractor submit marketing plans, procedures, and materials to the Administration for approval in accordance with R9-22-505 before implementation.
24. A statement that all representations made by contractors or authorized representatives are truthful and complete to the best of their knowledge.
25. A provision that the contractor is responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage, for itself and its employees, and that the Administration has no responsibility or liability for any of the taxes or insurance coverage.
26. A provision that the contractor agrees to comply with all applicable statutes and rules.

B. Each contract shall include all provisions necessary to ensure compliance with the applicable requirements of 42 CFR 434, Subpart C, as of October 1, 1995, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-402 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1).

R9-22-403. Subcontracts

A. Approval. Any subcontract entered into by a contractor to provide covered services to AHCCCS members or any amendment to a subcontract shall be subject to review and approval by the Director. No subcontract alters the legal responsibility of a contractor to the Administration to ensure that all activities under the contract are carried out.

B. Subcontracts. Each subcontract shall be in writing and include:
1. That the subcontract is to be governed by, and construed in accordance with all laws, rules, and contractual obligations of the contractor.
2. Provision to notify the Administration in the event the subcontract is amended or terminated.
3. Provision that assignment or delegation of the subcontract is voidable unless prior written approval is obtained from the Administration.
4. Provision to hold harmless the state, the Director, the Administration, and members in the event the contractor cannot or will not pay for covered services performed by the subcontractor.
5. Provision that the subcontract and subcontract amendments are subject to review and approval by the Director as set forth in these rules and that a subcontract or subcontract amendment may be terminated, rescinded, or cancelled by the Director for a violation of these rules.
6. Provision to hold harmless and indemnify the state, the Director, the Administration, and members against claim, liabilities, judgments, costs and expenses with respect to third parties, which may accrue against the state, the Director, the Administration, or members, through the negligence of the subcontractor.
7. Provision that members are not to be held liable for payment to providers in the event of contractor's bankruptcy, in compliance with 42 CFR 434, Subpart C, as of October 1, 1995, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
8. The requirements contained in R9-22-402(A)(1) through (A)(7), (A)(9), (A)(10), (A)(14), (A)(15), (A)(17), and (A)(24) through (A)(26) but substituting the term "subcontractor" wherever the term "contractor" is used.

C. Waiver. A contractor may submit a written request to the Administration requesting a waiver of the requirement that the contractor subcontract with a hospital in the contractor's service area. The request shall set forth the reasons a waiver is believed to be necessary and shall state all efforts the contractor has made to secure a subcontract. For good cause shown, the Administration may waive the hospital subcontract requirement. The Administration shall consider the following criteria in deciding whether to waive the hospital subcontract requirement:
1. The number of hospitals in the service area.
2. The extent to which the contractor's primary care physicians have staff privileges at noncontracting hospitals in the service area.
3. The size and population of, and the demographic distribution within, the service area.
4. Patterns of medical practice and care within the service area.

5. Whether the contractor has diligently attempted to negotiate a hospital subcontract in the service area.
6. Whether the contractor has any subcontracts in adjoining service areas with hospitals that are reasonably accessible to the contractor's members in the service area.
7. Whether the contractor's members can reasonably be expected to receive all covered services in the absence of a hospital subcontract.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-403 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended by adding subsection (C) effective October 1, 1987 (Supp. 87-4). Amended effective January 14, 1997 (Supp. 97-1).

R9-22-404. Contract Amendments; Mergers; Reorganizations

Any merger, reorganization, or change in ownership of a contractor shall require that the contractor submit the contract between the Administration and the contractor for amendment and prior approval by the Director. Additionally, any merger, reorganization, or change in ownership of a subcontractor that is related to or affiliated with the contractor shall constitute a contract amendment which requires the prior approval of the Director. To be effective, contract amendments shall be in writing and executed by the Director.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-404 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1).

R9-22-405. Suspension, Denial, Modification, or Termination of Contract

A. General. The Director may suspend, deny, refuse or fail to renew, or terminate a contract or subcontract for good cause which may include the following reasons:
1. Submitting any misleading, false, or fraudulent information with a claim for payment.
2. Submitting false information for the purpose of obtaining greater compensation than that to which the contractor is legally entitled.
3. Submitting an inaccurate or incomplete representation in the bidding process.
4. Failing to disclose or make available to the Administration, or its authorized representatives, records of services provided to eligible persons or members and records of payment made for the services.
5. Submitting false information for the purpose of obtaining authorization to provide services requiring authorization.
6. Over-providing services or delivering unnecessary services by inducing or otherwise causing an eligible person or member to receive services or items not required by the person or member or by directly furnishing the services or items.
7. Providing any services in violation of or not authorized by or otherwise precluded by licensure, certification, or other law.
8. Breaching the terms or conditions of a contract.
9. Having a member of the board, administrator, manager, or participating physician of a contractor convicted of a felony.
10. Giving or accepting a rebate, kickback, or fee or portion of a fee, or charging for referral of an eligible person or member.
11. Violating any provision of A.R.S. Title 36, Chapter 29, Title XIX of the Social Security Act, as amended, or any state or federal rule promulgated under those statutes.
12. Demonstrating an inability to perform obligations under a contractor agreement by prior conduct.
13. Being determined to have substantially breached a previous or existing contract agreement with another state agency.
14. Being previously found ineligible to participate in federal or state assembled medical programs by the Administration or any other state or federal governmental agency.
15. Failing to reimburse a subcontracting or noncontracting provider utilized by referral for the provision of medically necessary health care services to the contractor's members within 60 days of receipt of a valid claim unless a different period is specified by contract, or failing to ensure that future claims will be paid.
16. Failing to reimburse a noncontracting provider or nonprovider for the provision of emergency medical services provided to the contractor's members within 60 days of receipt of a valid claim, or failing to ensure that future claims will be timely paid.
17. Failing to provide and maintain quality health care service to eligible persons and members, as determined by standards established by state and federal statute or regulations.
18. Being determined to be endangering or to have endangered either, by omission of commission, the health, safety, or well-being of an eligible person or member.
19. Becoming insolvent, or filing proceedings in bankruptcy or reorganization under the United States Code, or assigning rights or obligations under the contract without the prior written consent of the Administration.
20. Failing or refusing to comply with the reporting or disclosure requirement of 42 CFR 455, Subpart B, as of October 1, 1995, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
21. Being determined to have committed fraud or abuse in accordance with 42 CFR 455, Subpart A, as of October 1, 1995, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
22. Being convicted of a criminal offense related to involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act of any person who has an ownership or control interest in the contractor or subcontractor, or is an agent or managing employee of the contractor or subcontractor.
23. Failing to conform to and abide by the applicable laws or rules of Arizona, the United States federal government and the Administration.

B. Modification and termination of the contract without cause. The contract may be modified or terminated at any time by mutual consent of the Administration and contractor. Additionally, the Administration may terminate or suspend the contract in whole or in part without cause effective 30 days after

mailing written notice of termination or suspension by certified mail, return receipt requested, to the contractor.

C. Notification. The Director shall provide the contractor written notice of intent to suspend, deny, fail to renew, or terminate a contract or related subcontract. The notice shall be provided to affected principals, enrolled members and other interested parties, and shall include the effective date of, and reason for, the action.

D. Records. All medical, financial, and other records shall be retained by a terminated contractor in accordance with federal and state laws and rules. Medical records or copies of medical records may be required to be submitted to the Director, or designee, within 10 working days of the effective date of contract termination.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-405 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of the amended rule similar to the emergency (Supp. 83-3). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1).

R9-22-406. Contract Compliance Sanction Alternative

A. Instead of using the sanctioning authority prescribed in R9-22-405, the Director may impose 1 or more of the following sanctions upon a contractor that violates any provision of these rules or of an AHCCCS contract:

1. Suspend any or all further member enrollment, by choice or assignment, for a period of time commensurate with the nature, term, and severity of the violation.
2. Withhold a percentage of the contractor's capitation prepayment, commensurate with the nature, term, and severity of the violation.

B. The Director shall provide a contractor with written notice specifying the sanction alternative, grounds for the sanction, and either the length of suspension or the amount of prepayment to be withheld.

C. Nothing contained in this Section shall be construed to prevent the Administration from imposing sanctions provided for by contract.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-406 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-406 repealed, new Section R9-22-406 adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as a permanent rule effective May 16, 1983; text of the Section identical to the emergency (Supp. 83-3). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1).

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-22-501. Pre-existing Conditions

A. Except as otherwise provided in Article 3 of this Chapter, a contractor shall be responsible for providing the full scope of covered services to each member from the effective date of eligibility until the time of notification of termination, suspension, or transfer of the member's enrollment. This responsibility includes providing treatment for all of a member's pre-existing conditions.

B. A contractor or subcontractor shall not adopt or use any procedure to identify individuals who have an existing or anticipated medical or psychiatric condition in order to discourage or exclude the individuals from enrolling in the contractor's health plan or encourage the individuals to enroll in another health plan.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-501 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-501 repealed, former Section R9-22-502 renumbered and adopted without change as Section R9-22-501 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-501 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-502. Availability and Accessibility of Service

A. A contractor shall provide adequate numbers of available and accessible:

1. Institutional facilities;
2. Service locations;
3. Service sites; and
4. Professional, allied, and paramedical personnel for the provision of covered services, including all emergency medical services for 24 hours a day, 7 days a week.

B. A contractor shall minimally provide the following:

1. A ratio of primary care providers to adults and children, as specified in contract;
2. A designated emergency services facility, providing care 24 hours a day, 7 days a week, accessible to members in each contracted service area. One or more physicians and 1 or more nurses shall be on call or on duty at the facility at all times;
3. An emergency services system employing at least 1 physician, registered nurse, physician's assistant, or nurse practitioner, accessible by telephone 24 hours a day, 7 days a week, to members who need information in an emergency, and to providers who need verification of patient membership and treatment authorization;
4. An emergency services call log or database to track the following information:
   a. Member's name,
   b. Address and telephone number,
   c. Date and time of call,
   d. Nature of complaint or problem, and
   e. Instructions given to member.
5. A written procedure for communicating emergency services information to a member's primary care provider, and other appropriate organizational units;
6. An appointment standard as specified in contract for the following:
   a. Emergency appointments;
   b. Urgent care appointments; and
   c. Routine care appointments.
7. Waiting times for members with appointments that do not exceed 45 minutes, except when the provider is unavailable due to an emergency.

C. A contractor shall have an affiliation with or subcontract with an organization or individual to provide primary care services.

The contractor shall agree to provide services under the primary care provider's guidance and direction.

1. A primary care provider selected by or to whom an enrolled member is assigned shall be responsible for:
   a. Supervising, coordinating, and providing initial and primary care to the member;
   b. Initiating referrals for specialty care;
   c. Maintaining continuity of member care; and
   d. Maintaining an individual medical record for each assigned member.
2. A primary care provider or specialist providing inpatient services to a member shall have staff privileges in a minimum of 1 general acute care hospital under subcontract with the contractor, within the service area of the contractor.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-502 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-502 renumbered without change as Section R9-22-501, former Section R9-22-503 renumbered and amended as Section R9-22-502 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-502 repealed, new Section R9-22-502 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-503. Reinsurance

A. Contractor-acquired reinsurance. A contractor may obtain reinsurance for coverage of prepaid capitated members. A contractor shall not obtain reinsurance to reduce liability below 25% of the applicable deductible level during any AHCCCS contract year. This limitation does not apply to reinsurance obtained by a contractor to cover the cost of services provided by noncontracting providers and nonproviders to members under emergency circumstances.

B. Administration reinsurance. For purposes of the Administration's reinsurance program, the insured entity shall be a prepaid plan with which the Administration contracts. Only costs incurred during the contract year in which a member is enrolled with a contractor qualify for reinsurance. Any movement of a member from membership with 1 contractor to membership with another contractor shall be cause for resetting the deductible level unless resetting is waived by the Administration.

C. Coinsurance and deductibles for members.
1. Coinsurance. As stated in the contract, the Administration shall pay a percentage of costs in excess of the deductible level incurred in paying for covered inpatient hospital services and when applicable, nursing facilities and acute medical and psychiatric services approved by the Director.
2. Deductible. A contractor shall pay the deductible for members.

D. Computation of the deductible level. The deductible level shall be determined by the costs paid by the contractor, or the AHCCCS fee schedule, if the costs are paid under a subcapitated arrangement.

E. Amounts in excess of the deductible level shall be paid based upon costs paid by the contractor, minus the coinsurance unless the costs are paid under a subcapitated arrangement. In subcapitated cases, the Administration shall base reimbursement of reinsurance encounters on the calculated AHCCCS allowed amount minus Medicare/TPL payments and applicable quick pay discounts.
1. The contractor shall maintain evidence that costs incurred have been paid by the contractor before submitting reinsurance encounters. This information is subject to AHCCCS Administration review.
2. First- and 3rd-party collections shall be reflected by the contractor as reductions in the encounters submitted on a dollar-for dollar-basis.
3. Payments made by contractor-purchased reinsurance are not considered 1st- and 3rd-party collections for the purpose of Administration reinsurance.

F. Encounter submission. A contractor shall prepare, review, verify, certify, and submit, encounters for consideration to the Administration.
1. The contractor shall certify that the services listed were actually rendered, medically necessary, and within the scope of AHCCCS benefits.
2. The contractor shall submit encounters in the format prescribed by the Administration.
3. The contractor shall initiate and evaluate an encounter for probable 1st-and 3rd-party liability before submitting the encounter for reinsurance consideration to the Administration, unless the encounter involves underinsured or uninsured motorist liability insurance, 1st- and 3rd-party liability insurance, or a tort-feasor.

G. Encounter processing. The Administration shall process reinsurance associated or related encounters submitted by a contractor.
1. The Administration shall accept for processing only those encounters that are submitted directly by an AHCCCS contractor and that comply with the conditions in subsections (B), (C), (E), and (F).
2. The Administration shall establish and maintain separate records of all reinsurance cases established and all payments and case reviews made to the contractor as a result of these cases.
3. The Administration shall subject a contractor to utilization of services and other evaluative reviews of care provided to a member that result in a reinsurance case.

H. Payment of reinsurance cases. The Administration shall reimburse a contractor for costs incurred in excess of the applicable deductible level calculated according to the provisions of subsection (E) and R9-22-703(B)(2).

I. The Administration may limit reinsurance reimbursement to a lower or alternative level of care if the Director or designee determines that the less costly alternative could and should have been used by the contractor. A contractor whose reinsurance case is reduced or denied shall be notified in writing by the Administration. The notification shall include the cause for reduction or denial and describe the applicable grievance and appeal process available under Article 8 of this Chapter.

J. The Administration or its contractors may arrange special contractual reinsurance terms for catastrophic cases. Catastrophic cases include, but are not limited to organ and bone marrow transplants (excluding kidney and cornea transplants which are covered under regular reinsurance), and hemophiliac cases. The contractor shall notify the AHCCCS Administration when a member is identified for possible reimbursement of AHCCCS-approved catastrophic cases. The determination of whether a case or type of case is catastrophic shall be made by the Director based on the following criteria:
1. Severity of medical condition, including prognosis; and
2. Average cost or average length of hospitalization and medical care, or both, in Arizona for the type of case under consideration.

Historical Note

Adopted as an emergency effective May 20, 1982, pursu-

ant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-503 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-503 renumbered and amended as Section R9-22-502, new Section R9-22-503 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective May 30, 1986 (Supp. 86-3). Amended subsection (D) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (F) and (G) effective December 22, 1987 (Supp. 87-4). Amended subsection (I) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions

A. A contractor or the contractor's marketing representative shall not offer or give any form of compensation or reward, or engage in any behavior or activity that may be reasonably construed as coercive, to induce or procure AHCCCS enrollment. Any marketing solicitation offering a benefit, good, or service, in excess of the covered services in Article 2 shall be deemed an inducement.

B. A marketing representative shall not misrepresent itself, the contracting health plan represented, or the AHCCCS program, through false advertising, false statements, or in any other manner to induce an eligible person or member of another contracting entity to enroll in the represented health plan.

1. The Administration shall deem violations of this subsection to include, but not be limited to, false or misleading claims, inferences, or representations that:
   a. An eligible person or member will lose benefits under the AHCCCS program or any other health or welfare benefits to which the eligible person or member is legally entitled, if the eligible person or member does not enroll in the represented contracting health plan;
   b. Marketing representatives are employees of the state or representatives of the Administration, a county, or any health plan other than the health plan with whom they are employed, or by whom they are reimbursed; and
   c. The represented health plan is recommended or endorsed as superior to its competition by any state or county agency, or any organization, unless the organization has certified its endorsement in writing to the health plan and the Administration.

C. A marketing representative shall not engage in any marketing or pre-enrollment practice that discriminates against an eligible person or a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.

D. The Administration shall hold a contractor responsible for the performance of any marketing representative, subcontractor or agent, program, or process under its employ or direction and shall make the contractor subject to the contract sanctions in this Chapter.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-504 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-504 repealed, former Section R9-22-505 renumbered and adopted without change as Section R9-22-504 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-504 repealed, former Section R9-22-528 renumbered and amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-505. Approval of Advertisements and Marketing Materials

A. A contractor shall submit its proposed advertisements, marketing materials, and paraphernalia for review and approval by the Administration before distributing the materials or implementing the activities.

B. A contractor shall submit all proposed marketing materials in writing to the Administration.

C. The Administration shall review and approve or disapprove all marketing materials. The Administration shall include a statement of objections and recommendations in a notice of disapproval.

D. To minimize the expense of revising advertising or other copy, a contractor may submit the marketing materials in draft form, subject to final approval and filing of a proof or final copy.

E. A contractor shall provide 2 copies of the proof or final approved copy of marketing materials to the Administration.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-505 adopted as an emergency expired, former Section R9-22-506 adopted as an emergency now adopted, amended and renumbered as Section R9-22-505 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-505 renumbered without change as Section R9-22-504, new Section R9-22-505 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-505 renumbered and amended as Section R9-22-509, former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5). Editorial correction, spelling of "paraphernalia" in subsection (A) (Supp. 87-4). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-506. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-506 adopted as an emergency adopted, amended and renumbered as Section R9-22-505, former Section R9-22-507 adopted as an emergency now adopted, amended and renumbered as Section R9-22-506 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (D) effective December 22, 1987 (Supp. 87-4). Repealed effective April 13, 1990 (Supp. 90-2). New Section adopted effective December 13, 1993 (Supp. 93-4). Repealed effective December 8, 1997 (Supp. 97-4).

R9-22-507. Member Record

A contractor shall maintain a member service record that contains at least the following for each member:

1. Encounter data,
2. Grievances and appeals,
3. Any informal complaints, and

4. Service information.

Historical Note
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-507 adopted as an emergency adopted, amended and renumbered as Section R9-22-506, former Section R9-22-508 adopted as an emergency now adopted, amended and renumbered as Section R9-22-507 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-507 repealed, new Section R9-22-507 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-508. Limitation of Benefit Coverage for Illness or Injury due to Catastrophe

The Director may limit the scope of health care benefits provided by a prepaid capitated contractor to exclude the care of illness or injury that results from, or is greatly aggravated by, a catastrophic occurrence, including an act of declared or undeclared war, that occurs after enrollment.

Historical Note
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-508 adopted as an emergency adopted, amended and renumbered as Section R9-22-507, former Section R9-22-509 adopted as an emergency now adopted, amended and renumbered as Section R9-22-508 as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-509. Transition and Coordination of Member Care

A. The Administration shall coordinate and implement disenrollment and re-enrollment procedures when a member's change of residency requires a change in contractor.

B. A contractor shall assist in the transition of members to and from other AHCCCS contractors.
1. Both the receiving and relinquishing contractor shall:
   a. Coordinate with the other contractor to facilitate and schedule appointments for medically necessary services for the transitioned member within the Administration's timelines specified in the contract. A contractor's policies and procedures regarding transition of members are subject to review and approval by the Administration;
   b. Assist in the referral of transitioned members to other community health agencies or county medical assistance programs for medically necessary services not covered by the Administration, as appropriate; and
   c. Develop policies and procedures to be followed when transitioning members who have significant medical conditions; are receiving ongoing services; or have, at the time of the transition, received prior authorization or approval for undelivered, specific services.
2. The relinquishing contractor shall notify the receiving contractor of relevant information about the member's medical condition and current treatment regimens within the timelines defined in contract;
3. The relinquishing contractor shall forward medical records and other materials to the receiving contractor. The cost of reproducing and forwarding medical records and other materials shall be borne by the relinquishing contractor;
4. Within the contract-specified timelines, the receiving contractor shall ensure that the member selects or is assigned to a primary care provider, and provide the member with:
   a. Information regarding the contractor's providers,
   b. Emergency numbers, and
   c. Instructions about how to obtain new services.

C. A contractor shall not use a county or nonprovider health resource alternative that diminishes the contractor's contractual responsibility or accountability for providing the full scope of covered services. Referrals made to other health agencies by a contractor, primarily to reduce expenditures incurred by the contractor on behalf of its members, may result in the application of sanctions described in this Chapter.

D. A contractor may transfer a member from a noncontracting provider to a contracting provider's facility as soon as a transfer will not be harmful to the member's health as authorized by the member's primary care provider or the contractor's Medical Director. A member's plan shall pay the cost of transfer.

Historical Note
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-509 adopted as an emergency adopted, amended and renumbered as Section R9-22-508, former Section R9-22-510 adopted as an emergency now adopted and renumbered as Section R9-22-509 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-509 repealed, former Section R9-22-505 renumbered and amended as Section R9-22-509 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-510. Transfer of Members

A contractor shall implement procedures to allow a member to transfer from the primary care provider of record to another primary care provider within the same contracting organization. Criteria for a transfer include, but are not be limited to:
1. Change in the member's health, requiring a different medical focus;
2. Change in the member's residency resulting in difficulty in obtaining services from the assigned primary care provider; or
3. Identification of any problem between the member and the primary care provider, resulting in deterioration of the primary care provider - member relationship.

Historical Note
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-510 adopted as an emergency adopted and renumbered as Section R9-22-509, former Section R9-22-511 adopted as an emergency now adopted, amended and renumbered as Section R9-22-510 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-510 repealed, new Section R9-22-510 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-511. Fraud or Abuse

A contractor, provider, or nonprovider shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse.

Historical Note
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-511 adopted as an emergency adopted, amended and renumbered as Section R9-22-510, former Section R9-22-512 adopted as an emergency now adopted, amended and renumbered as Section R9-22-511

as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-511 repealed, new Section R9-22-511 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-512. Release of Safeguarded Information by the Administration and Contractors

A. The Administration, contractors, providers, and noncontracting providers shall safeguard information concerning an applicant, eligible person, or member, which includes the following:
1. Name and address;
2. Social Security number;
3. Social and economic conditions or circumstances;
4. Agency evaluation of personal information;
5. Medical data and services, including diagnosis and history of disease or disability;
6. State Data Exchange (SDX) tapes from the U.S. Social Security Administration; and
7. Information system tapes from the Arizona Department of Economic Security.

B. The restriction upon disclosure of information does not apply to:
1. Summary data;
2. Statistics;
3. Utilization data; and
4. Other information that does not identify an applicant, eligible person, or member.

C. The Administration, contractors, providers, and noncontracting providers shall use or disclose information concerning an eligible person, applicant, or member only under the conditions specified in subsection (D), (E), and (F) and only to:
1. The person concerned,
2. Individuals authorized by the person concerned, and
3. Persons or agencies for official purposes.

D. Safeguarded information shall be viewed by or released to only:
1. An applicant;
2. An eligible person;
3. A member; or
4. An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:
   a. An Administration employee or its authorized representative, county eligibility official, or responsible caseworker is present during the examination of the eligibility record; or
   b. As outlined in subsection (E) after written notification to the provider, and at a reasonable time and place.

E. An eligibility case record, medical record, and any other AHCCCS-related confidential and safeguarded information regarding an eligible person, member, applicant, or unemancipated minor shall be released to individuals authorized by the eligible person, member, applicant, or unemancipated minor only under the following conditions:
1. Authorization for release of information is obtained from the eligible person, member, applicant, or designated representative;
2. Authorization used for release is a written document, separate from any other document, that specifies the following information:
   a. Information or records, in whole or in part, which are authorized for release;
   b. To whom release is authorized;
   c. The period of time for which the authorization is valid, if limited; and
   d. A dated signature of the adult and mentally competent member, eligible person, applicant, or designated representative. If the eligible person, member, or applicant is a minor, the signature of a parent, custodial relative, or designated representative shall be required unless the minor is sufficiently mature to understand the consequences of granting or denying authorization. If the eligible person, member, or applicant is mentally incompetent, authorization shall be according to A.R.S. § 36-509;
3. If an appeal or grievance is filed, the eligible person, member, applicant, or designated representative shall be permitted to review and obtain or copy any nonprivileged record necessary for the proper presentation of the case.

F. Release of safeguarded information to individuals or agencies for official purposes:
1. Official purposes directly related to the administration of the AHCCCS program are:
   a. Establishing eligibility and post-eligibility treatment of income, as applicable;
   b. Determining the amount of medical assistance;
   c. Providing services for eligible persons and members;
   d. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the AHCCCS program;
   e. Performing evaluations and analyses of AHCCCS operations;
   f. Filing liens on property as applicable;
   g. Filing claims on estates, as applicable; and
   h. Filing, negotiating, and settling medical liens and claims.
2. For official purposes related to the administration of the AHCCCS program and only to the extent required in performance of duties, safeguarded information, including case records and medical records, may be disclosed to the following persons without the consent of the applicant, member, or eligible person:
   a. Employees of the Administration;
   b. Employees of the U.S. Social Security Administration;
   c. Employees of the Arizona Department of Economic Security;
   d. Employees of the Arizona Department of Health Services;
   e. Employees of the U.S. Department of Health and Human Services;
   f. Employees of contractors, program contractors, providers, and subcontractors;
   g. Employees of the Arizona Attorney General's Office; or
   h. Employees of counties including Boards of Supervisors, AHCCCS eligibility offices, and the County Attorney, as applicable.
3. Law enforcement officials:
   a. Information may be released to law enforcement officials without the applicant's, eligible person's, or member's written or verbal consent, for the purpose of an investigation, prosecution, or criminal or civil proceeding relating to the administration of the AHCCCS program.
   b. Medical record. The Administration and contractors shall release safeguarded information contained in a member's medical record to law enforcement officials without the member's consent only if the mem-

ber is suspected of fraud or abuse against the AHCCCS program.

c. A contractor shall release the medical record or information in the case record or other information developed in case management or utilization management operations without the member's written or verbal consent, for the purpose of an investigation, prosecution, or similar criminal proceeding not in connection with the Administration, only if the law enforcement official requesting the information has statutory authority to obtain the information.

4. The Administration may release safeguarded information including case records and medical records to a review committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant, eligible person, or member.
5. In accordance with the 1634 Agreement between the State of Arizona and the U.S. Department of Health and Human Services, a recipient of information or records disclosed or used for an official purpose shall comply with the 1634 Agreement, dated October 1, 1982, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
6. Providers shall furnish requested records to the Administration and its contractors at no charge.

G. The holder of a medical record of a former applicant, eligible person, or member shall obtain written consent from the former applicant, eligible person, or member before transmitting the medical record to a primary care provider.

H. Subcontractors are not required to obtain written consent from an eligible person or member before transmitting the eligible person's or member's medical records to a physician who:

1. Provides a service to the eligible person or member under subcontract with the program contractor,
2. Is retained by the subcontractor to provide services that are infrequently used or are of an unusual nature, and
3. Provides a service under the contract.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-512 adopted as an emergency adopted, amended and renumbered as Section R9-22-511, former Section R9-22-513 adopted as an emergency now adopted and renumbered as Section R9-22-512 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-512 repealed, new Section R9-22-512 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-513. Discrimination Prohibition

A. A contractor, provider, and nonprovider shall not discriminate against an eligible person or member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental disability in accordance with Title VI of the U.S. Civil Rights Act of 1964, 42 USC, Section 2000d, and rules and regulations promulgated according to, or as otherwise provided by law. For the purpose of providing covered service under contract according to A.R.S. Title 36, Ch. 29, discrimination includes, but is not limited to, the following if done on the grounds of the eligible person's or member's race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental disability:

1. Denying or providing an eligible person or ~~a~~ member any covered service or availability of a facility;
2. Providing to an eligible person or member any covered service that is different, or is provided in a different manner or at a different time from that provided to other AHCCCS members under contract, other public or private members, or the public at large except when medically necessary;
3. Subjecting an eligible person or ~~a~~ member to segregation or separate treatment in any manner related to the receipt of any covered service; restricting a member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and
4. Assigning to an eligible person or member times or places for the provision of services that are different from those assigned to other AHCCCS members under contract.

B. All provisions in this Section shall not apply to an eligible person defined as eligible according to A.R.S. § 36-2901 (4)(d) through (4)(g), who is not required by statute or these rules to obtain health care services at a county-owned and operated facility, if the health care facility is awarded a contract as an AHCCCS provider. A person eligible according to A.R.S. § 36-2901 (4)(b) shall have freedom of choice in selecting membership with an AHCCCS contractor in all instances in which more than 1 choice of contractor is available. However, an eligible person shall become a member of a county program and receive services in a county facility, if a county is the only AHCCCS contractor for the eligible person in the service area.

C. A contractor shall take affirmative action to ensure that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental disability, except where medically indicated.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-513 adopted as an emergency adopted and renumbered as Section R9-22-512, former Section R9-22-514 adopted as an emergency now adopted, amended and renumbered as Section R9-22-513 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-513 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-513 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-514. Equal Opportunity

A contractor shall, in all solicitations or advertisements for employees placed by, or, on behalf of the contractor:

1. Specify that it is an equal opportunity employer;
2. Send a notice provided by the Administration to each labor union representative or worker with a collective bargaining agreement, or other contract or understanding, stating that the contractor is an equal opportunity employer; and
3. Post copies of the notice in conspicuous places available to employees and applicants for employment.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-514 adopted as an emergency adopted, amended and renumbered as Section R9-22-513, former Section R9-22-515 adopted as an emergency now adopted, amended and renumbered as Section R9-22-514 as a permanent rule effective August 30, 1982 (Supp. 82-

4). Former Section R9-22-514 repealed, former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-515. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-515 adopted as an emergency adopted, amended and renumbered as Section R9-22-514, former Section R9-22-517 adopted as an emergency now adopted, amended and renumbered as Section R9-22-515 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-515 repealed, former Section R9-22-522 renumbered and amended as Section R9-22-515 effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

R9-22-516. Renumbered

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-516 adopted as an emergency expired, former Section R9-22-518 adopted as an emergency now adopted, amended and renumbered as Section R9-22-516 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-516 renumbered as Section R9-22-513 effective October 1, 1985 (Supp. 85-5).

R9-22-517. Renumbered

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-517 adopted as an emergency adopted, amended and renumbered as Section R9-22-515, former Section R9-22-519 adopted as an emergency now adopted and renumbered and amended as Section R9-22-517 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5).

R9-22-518. Information to Enrolled Members

A. Each contractor shall produce and distribute printed information materials to each member or family unit within 10 days of receipt of notification of enrollment from the Administration. The information materials shall be written in English and all languages used by 200 members or 5 %, whichever is greater, of the enrolled population. The informational materials must meet the requirements specified in the contractor's current contract.

B. A contractor shall provide a member with the name, address, and telephone number of the member's primary care provider within 10 days from the date of enrollment. This notice shall include information on how the member may change primary care providers, if dissatisfied with the primary care provider assigned.

C. A contractor shall revise and distribute to members a service guide insert describing any change that the contractor proposes to make in services provided or service locations. The insert shall be distributed to all affected members or family units at least 14 days before a planned change. Notification shall be provided as soon as possible when unforeseen circumstances require an immediate change in services, sites or locations.

D. A contractor shall submit informational and educational materials for approval by the Administration before distributing the materials to members and families.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-518 adopted as an emergency adopted, amended and renumbered as Section R9-22-516, former Section R9-22-520 adopted as an emergency now adopted, amended and renumbered as Section R9-22-518 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-518 repealed, new Section R9-22-518 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-519. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-519 adopted as an emergency adopted, amended and renumbered as Section R9-22-517, former Section R9-22-521 adopted as an emergency now adopted, amended and renumbered as Section R9-22-519 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-519 repealed, new Section R9-22-519 adopted effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

R9-22-520. Financial Statements, Periodic Reports and Information

A. Upon request by the Administration, a contractor shall furnish to the Administration information from its records relating to contract performance.

B. A contractor shall provide the Administration with the following:

1. An annual certified financial report prepared by a certified public accountant submitted no later than 120 days after the close of the contractor's fiscal year. The certified public accountants who prepare the report shall be independent of the contractor, subcontracting entities, their officers or directors, and any affiliates.
2. Quarterly financial statements no later than 60 days after the end of the reporting month.
3. Monthly financial statements, if required by the Administration submitted no later than 60 days after the end of the reporting period.
4. Disclosures of information on ownership and control required by 42 CFR 455, Subpart B, September 30, 1986, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
5. Cost reporting, audits, and financial reporting as specified in contract or provider agreement.

C. All financial statements shall identify separately all AHCCCS-related transactions, including allocations of overhead and other shared expenses where applicable. A contractor shall provide supplemental schedules describing all inter-entity transactions and eliminations for the Administration to use in analyzing the financial status of the entire health care delivery system.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-520 adopted as an emergency adopted, amended and renumbered as Section R9-22-518,

former Section R9-22-522 adopted as an emergency now adopted, amended and renumbered as Section R9-22-520 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-520 repealed, new Section R9-22-520 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-521. Program Compliance Audits

A. The Administration shall conduct a program compliance audit of a contractor at least once every 12 months during the term of its contract with the contractor. Unless the Administration determines that advance notice will render a program compliance audit less useful, a contractor will be notified approximately 3 weeks in advance of the date of an on-site program compliance audit. The Administration may conduct, without prior notice, inspections of contractor facilities or perform other elements of a program compliance audit, either in conjunction with the program compliance audit or as part of an unannounced inspection program.

B. A review team may perform any or all of the following procedures:

1. Conduct private interviews and group conferences with members, physicians, and other health professionals and members of the contractor's administrative staff including, but not limited to, the contractor's principal management persons;
2. Examine records, books, reports, and papers of the contractor and any management company, and all providers or subcontractors providing health care and other services to the health plan. The examination may include, but not be limited to: minutes of medical staff meetings, peer review and quality of care review records, duty rosters of medical personnel, appointment records, written procedures for the internal operation of the health plan, contracts and correspondence with members and with providers of health care services and other services to the plan, and additional documentation deemed necessary by the Administration to review the quality of medical care.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-521 adopted as an emergency adopted, amended and renumbered as Section R9-22-519, former Section R9-22-523 adopted as an emergency now adopted, amended and renumbered as Section R9-22-521 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-521 repealed, new Section R9-22-521 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-522. Quality Management/Utilization Management (QM/UM) Requirements

A. A contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements specified in this Section and in contract. The contractor shall ensure compliance with QM/UM requirements that are accomplished through delegation or subcontract with another party.

B. A contractor shall:

1. Submit a written QM/UM plan that includes a description of the systems, methodologies, protocols, and procedures to be used in:
   a. Monitoring and evaluating the types of services,
   b. Identifying the numbers and costs of services provided,
   c. Assessing and improving the quality and appropriateness of care and services,
   d. Evaluating the outcome of care provided to members, and
   e. Determining the steps and actions necessary to improve service delivery.
2. Submit the QM/UM plan on an annual basis within timelines specified in contract. If the QM/UM plan is changed during the year, the contractor shall submit the revised plan before implementation;
3. Receive approval from the Administration before implementing the initial QM/UM plan;
4. Ensure that a QM/UM committee operates under the control of the contractor's medical director, and includes representation from medical and executive management personnel. The committee shall:
   a. Oversee the development, revision and implementation of the QM/UM plan; and
   b. Ensure and allocate qualified QM/UM personnel and sufficient resources to implement the contractor's QM/UM activities.
5. Ensure that the QM/UM activities include at least:
   a. Prior authorization for non-emergency or scheduled hospital admissions;
   b. Concurrent review of inpatient hospitalization;
   c. Retrospective review of hospital claims;
   d. Program and provider audits designed to detect over or under utilization, service delivery effectiveness, and outcome;
   e. Medical records audits;
   f. Surveys to determine satisfaction of members;
   g. Assessment of the adequacy and qualifications of the contractor's provider network;
   h. Review and analysis of QM/UM data; and
   i. Other activities necessary to improve the quality of care and the efficient, cost effective delivery and utilization of services.

C. An eligible person's or member's primary care provider shall maintain medical records that:

1. Are detailed and comprehensive and identify:
   a. All medically necessary services provided to the member by the contractor and the subcontractors, and
   b. All emergency services provided by nonproviders for an eligible person or member.
2. Conform to professional medical standards and practices for documentation of medical diagnostic and treatment data;
3. Facilitate follow-up treatment; and
4. Permit professional medical review and medical audit processes.

D. A subcontractor or its designee shall forward medical records or copies of medical records of all members assigned to the subcontractor or for whom the subcontractor has provided services, within 30 days following termination of a contract between the subcontractor and the contractor.

E. The Administration shall monitor contractors and their providers to ensure compliance with Administration QM/UM requirements and adherence to the contractor QM/UM plan.
1. A contractor and its providers shall cooperate with the Administration in the performance of its QM/UM monitoring activities; and
2. A contractor and its providers shall develop and implement mechanisms for correcting deficiencies identified through the Administration's QM/UM monitoring.

Historical Note
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-522 adopted as an emergency adopted, amended and renumbered as Section R9-22-520, former Section R9-22-524 adopted as an emergency now adopted and renumbered as Section R9-22-522 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-522 renumbered and amended as Section R9-22-515, new Section R9-22-522 adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-523. Financial Resources

A. A contractor or offeror shall demonstrate upon request to the Administration that it has:
1. Adequate financial reserves,
2. Administrative abilities, and
3. Soundness of program design to carry out its contractual obligations.

B. As specified in A.R.S. § 36-2903, the Director requires that contract provisions include, but not be limited to:
1. Maintenance of deposits,
2. Performance bonds,
3. Financial reserves, or
4. Other financial security.

Historical Note
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-523 adopted as an emergency adopted, amended and renumbered as Section R9-22-521, former Section R9-22-525 adopted as an emergency now adopted, amended and renumbered as Section R9-22-523 as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-524. Continuity of Care

A contractor shall establish and maintain a system to ensure continuity of care which shall, at a minimum, include:
1. Referring members who need specialty health care services;
2. Monitoring members with chronic medical conditions;
3. Providing hospital discharge planning and coordination including post-discharge care; and
4. Monitoring operation of the system through professional review activities.

Historical Note
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-524 adopted as an emergency adopted and renumbered as Section R9-22-522, former Section R9-22-526 adopted as an emergency now adopted, amended and renumbered as Section R9-22-524 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-524 repealed, new Section R9-22-524 adopted effective October 1, 1985 (Supp. 85-4). Amended effective December 8, 1997 (Supp. 97-4).

R9-22-525. Repealed

Historical Note
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-525 adopted as an emergency adopted, amended and renumbered as Section R9-22-523, former Section R9-22-527 adopted as an emergency now adopted, amended and renumbered as Section R9-22-525 as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1985 (Supp. 85-5).

R9-22-526. Renumbered

Historical Note
Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of the permanent rule identical to the emergency (Supp. 83-3). Former Section R9-22-526 repealed, new Section R9-22-526 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-1).

R9-22-527. Renumbered

Historical Note
Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5).

R9-22-528. Renumbered

Historical Note
Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-528 renumbered and amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5).

R9-22-529. Renumbered

Historical Note
Adopted as Section R9-22-529 effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5).

ARTICLE 6. REQUEST FOR PROPOSALS (RFP)

R9-22-601. General Provisions

A. This Article applies to the expenditure of all public monies by the Administration for covered services under Articles 2 and 12 except as otherwise provided by law. The Administration shall ensure that it has conflict-of-interest safeguards for officers and employees of the state with responsibilities relating to contracts specified in 42 U.S.C. 1396u-2(d)(3), August 5, 1997, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. If it is deemed by the Administration to be in the best interest of the state, the Administration may cancel an RFP or reject any and all proposals, in whole or in part, as specified in the RFP. The reasons for cancellation or rejection shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if an RFP is cancelled or if a proposal is rejected in whole or in part.

C. The Administration may conduct an investigation of a person or organization who has ownership or management interests defined within 42 CFR 455.101, in corporate offerors and affiliated corporate organizations of an offeror. 42 CFR 455.101, September 30, 1986, is incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

D. A proposal may be opened publicly and the name of the offeror announced and recorded. All other information contained in a proposal shall be confidential. A proposal shall be open for public inspection after contract award unless the Administration determines that disclosure is not in the best interest of the state.

E. Failure by an offeror to supply information requested by the Administration is sufficient basis for rejection of the offeror's proposal by the Administration.

F. Disclosure of information pertaining to an offeror's proposal by the offeror to any other offeror or person prior to contract award is prohibited and may be grounds for rejecting a proposal.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-601 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1).

R9-22-602. Request for Proposals (RFP); Contract Award

A. RFP content. The following items shall be included in an RFP:
1. The instructions and information to an offeror concerning the proposal submission requirements, including:
   a. The deadline for submitting a proposal,
   b. The address of the office at which a proposal is to be received,
   c. The period during which the RFP shall remain open, and
   d. Any special instructions and information;
2. The service description, covered populations, geographic coverage, and a delivery or performance schedule;
3. The contract terms and conditions, including bonding or other security requirements, if applicable;
4. The factors used to evaluate a proposal;
5. The location of and method of obtaining documents that are incorporated by reference;
6. A requirement that the offeror acknowledge receipt of all RFP amendments issued by the Administration;
7. The type of contract to be used and a copy of a proposed contract form or provisions;
8. The length of the contract service;
9. A requirement for cost or pricing data;
10. The minimum RFP requirements; and
11. A provision requiring an offeror to certify that the submission of a proposal does not involve collusion or other anti-competitive practices.

B. Evaluation of a proposal.
1. The Administration shall evaluate a proposal based on the evaluation factors listed in the RFP.
2. The Administration may initiate discussions with a responsive and responsible offeror to clarify and assure full understanding of an offeror's proposal. The Administration shall provide an offeror fair treatment with respect to discussion and revision of a proposal. The Administration shall not disclose information derived from a proposal submitted by a competing offeror.
3. The Administration may issue a written request for best and final offers. The request shall state the date, time, and place for the submission of best and final offers.
4. Best and final offers may be requested only once unless the Administration determines that it is advantageous to the state to request additional best and final offers. The written request for best and final offers shall inform the offeror that if the offeror does not submit a notice of withdrawal or a best and final offer, the immediate previous offer shall be construed as the offeror's best and final offer.
5. The Administration shall provide written notification to an offeror whose proposal is rejected. The rejection notice shall be part of the contract file and public record.

C. Contract award. The Administration shall award the contract to the responsible and responsive offeror whose proposal is deemed most advantageous to the state. If the Administration determines that multiple contracts are in the best interest of the state, the Administration may award multiple contracts. The contract file shall contain the basis on which the award is made.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-602 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1).

R9-22-603. Contract Records

All contract records shall be retained for a period of 5 years and disposed of under A.R.S. § 41-2550.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-603 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1).

R9-22-604. Contract or Proposal Protests; Appeals

A. Grievances related to contract performance. This Section shall not apply to grievances related to contract performance. Any contract performance grievance shall be governed by R9-22-804.

B. Resolution of a proposal protest. The procurement officer issuing an RFP shall have the authority to resolve proposal protests. An appeal from the decision of the procurement officer shall be made to the Director.

C. Filing of a protest.
1. An interested party may file a protest with the procurement officer regarding:
   a. An RFP issued by the Administration,
   b. A proposed award, or
   c. An award of a contract.

2. The protest shall be in writing and shall include the following information:
   a. The name, address, and telephone number of the protester;
   b. The signature of the protester or protester's representative;
   c. Identification of an RFP or contract number;
   d. A detailed statement of the legal and factual grounds of the protest including copies of any relevant documents; and
   e. The relief requested.

D. Time for filing a protest.
1. A protest based on alleged improprieties in an RFP shall be filed before the due date for receipt of proposals.
2. A protest alleging improprieties that do not exist in the original RFP but are subsequently incorporated into the RFP before the due date for receipt of proposals shall be filed prior to the amended due date for receipt of proposals.
3. In cases other than those covered in subsections (D)(1) and (2), a protest shall be filed within 10 days after the protester knows or should have known the basis of the protest.

E. Stay of procurements during the protest. If a protest is filed before the contract award, the procurement officer may issue a written stay of the contract award if:
1. A reasonable probability exists that the protest will be sustained, and
2. The stay of the contract award is not contrary to the best interest of the state.

F. Decision by the procurement officer.
1. The procurement officer shall issue a written decision within 14 days after a protest has been filed. The decision shall contain an explanation of the basis of the decision.
2. The procurement officer shall furnish a copy of the decision to the protester by:
   a. Certified mail, return receipt requested; or
   b. Any method that provides evidence of receipt.
3. The Administration may extend, for good cause, the time-limit for decisions in subsection (F)(1) for a time not to exceed 30 days. The procurement officer shall notify the protester in writing that the time for the issuance of a decision has been extended and the date by which a decision shall be issued.
4. If the procurement officer fails to issue a decision within the time-limits in subsection (F)(1) or (3) the protester may proceed as if the procurement officer issued an adverse decision.

G. Remedies.
1. If the procurement officer sustains the protest in whole or in part and determines that the RFP, proposed contract award, or contract award does not comply with applicable statutes and rules, the procurement officer shall order an appropriate remedy.
2. In determining an appropriate remedy, the procurement officer shall consider all the circumstances of the procurement or proposed procurement, including:
   a. Seriousness of the procurement deficiency,
   b. Degree of prejudice to other interested parties or to the integrity of the RFP process,
   c. Good faith of the parties,
   d. Extent of performance,
   e. Costs to the state, and
   f. Urgency of the procurement.
3. An appropriate remedy may include 1 or more of the following:
   a. Terminate the contract;
   b. Reissue the RFP;
   c. Issue a new RFP;
   d. Award a contract consistent with statutes, rules, and the terms of the RFP; or
   e. Any relief determined necessary to ensure compliance with applicable statutes and regulations.

H. Appeals to the Director.
1. An interested party shall file an appeal from a decision by the procurement officer with both the Director and the procurement officer within 5 days from the date the decision is received. The date the decision is received shall be determined according to R9-22-604(F)(2).
2. The appeal shall contain:
   a. The information required in subsection (C)(2),
   b. A copy of the decision of the procurement officer,
   c. The alleged factual or legal error in the decision of the procurement officer on which the appeal to the Director is based, and
   d. A request for hearing unless the interested party requests that the Director's decision be based solely upon the contract record.

I. Stay of contract award during an appeal to the Director. If an appeal is filed before a contract award and the contract award is stayed by the procurement officer under subsection (E), the filing of an appeal to the Director shall automatically continue the stay unless the Director issues a written determination that the contract award is necessary to protect the best interest of the state.

J. Dismissal. No appeal hearing shall be scheduled, and the Director shall dismiss an appeal with a written determination if:
1. The appeal does not state a basis for protest,
2. The appeal is untimely under subsection (H), or
3. The appeal is moot.

K. Hearing. Hearings requested under this rule shall be conducted under Article 8.

Historical Note
Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1).

R9-22-605. Repealed

Historical Note
Adopted effective January 31, 1986 (Supp. 86-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1).

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-701. Scope of the Administration's Liability; Payments to Contractors

A. The Administration shall bear no liability for providing covered services to or completing a plan of treatment for any member or eligible person beyond the date of termination of the individual's eligibility or enrollment.

B. The Administration shall make all payments to a contractor in accordance with the terms and conditions of the contract executed between the contractor and the Administration and in accordance with these rules.

C. The Administration shall bear no liability for subcontracts that a contractor executes with other parties for the provision of administrative or management services, medical services, or covered health care services, or for any other purpose. A contractor shall indemnify and hold the Administration harmless from any and all liability arising from the contractor's subcon-

tracts, shall bear all costs of defense of any litigation over the liability, and shall satisfy in full any judgment entered against the Administration in litigation involving the contractor's subcontracts.

D. The Administration shall make capitation payments monthly to a contractor who meets the requirements in A.R.S. § 36-2903(N).

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-701 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-701 repealed, new Section R9-22-701 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective September 22, 1997 (Supp. 97-3).

R9-22-702. Prohibitions Against Charges to Members or Eligible Persons

A. A contractor, subcontractor, or other provider of care or services shall not charge, submit a claim, demand, or otherwise collect payment from a member or eligible person, or a person acting on behalf of a member or eligible person, for any covered service except to collect an authorized co-payment or payment for additional services. A prepaid capitated contractor shall have the right to recover from a member that portion of payment made by a 3rd party to the member when the payment duplicates AHCCCS paid benefits and has not been assigned to the prepaid contractor. A prepaid capitated contractor who makes a claim under this provision shall not charge more than the actual, reasonable cost of providing the covered services.

B. A provider shall not bill or make any attempt to collect payment, directly or through a collection agency, from an individual claiming to be AHCCCS eligible without 1st receiving verification from the Administration that the individual was ineligible for AHCCCS on the date of service or that the services provided were not covered by AHCCCS.

C. A provider, including a noncontracting provider, may bill an eligible person for medical expenses incurred during a period of time when the eligible person willfully withheld material information from the provider or gave false information to the provider pertaining to the eligible person's AHCCCS eligibility or enrollment status that caused payment to be denied.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-702 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text identical to the emergency (Supp. 83-3). Former Section R9-22-702 repealed, new Section R9-22-702 adopted effective October 1, 1983 (Supp. 83-5). Amended by adding subsection (B) effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3).

R9-22-703. Claims

A. Claims submission to contractors. A provider shall submit to a capitated contractor all claims for services rendered to a member enrolled with the capitated contractor, including services rendered during a prior period for which the capitated contractor is responsible.

B. Claims submission to the AHCCCS Administration.

1. A provider, noncontracting provider, or nonprovider shall ensure that a claim for covered services provided to an AHCCCS-eligible person is initially received by the AHCCCS Claims Administration not later than 9 months from the date of service or 9 months from the date of eligibility posting, whichever is later. The Administration shall deny a claim not received within the 9-month period from the date of service or 9 months from the date of eligibility posting, whichever is later. If a claim meets the 9-month limitation, the provider, noncontracting provider, or nonprovider shall file a clean claim which is received by the AHCCCS Claims Administration not later than 12 months from the date of service or 12 months from the date of eligibility posting, whichever is later.
2. Exceptions to the 9-month and 12-month rules are:
   a. The Administration shall not consider a reinsurance claim for payment unless the claim is received by the AHCCCS Claims Administration not later than 9 months from the close of the contract year in which the claim is incurred or 9 months after the date of eligibility posting, whichever is later. If a claim meets the 9-month limitation, the contractor shall file a clean claim which is received by the AHCCCS Claims Administration not later than 12 months from the close of the contract year in which the claim is incurred or 12 months after the date of eligibility posting, whichever is later.
   b. The 9-month deadline for an inpatient hospital claim begins on the date of discharge for each claim.

C. Claims processing.

1. If a claim contains erroneous or conflicting information, exceeds parameters, fails to process correctly, does not match the AHCCCS files, or requires manual review to be resolved, the Administration shall report the claim to the provider with a remittance advice.
2. The Administration shall process a hospital claim in accordance with R9-22-712.

D. Overpayments for AHCCCS services. When an AHCCCS overpayment is made to a provider, noncontracting provider, nonprovider, or contractor, the provider, noncontracting provider, nonprovider, or contractor shall notify AHCCCS that an overpayment was made. The Administration shall recoup an overpayment from a future claim cycle, or, at the discretion of the Director, require the provider, noncontracting provider, nonprovider, or contractor to return the incorrect payment to AHCCCS.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R-22-703 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-703 repealed, new Section R9-22-703 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (1) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective September 16, 1987 (Supp. 87-3). Amended effective May 30, 1989 (Supp.

89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3).

R9-22-704. Transfer of payments

A. Payments permitted. Payments may be made to other than the contractor, noncontracting provider or nonprovider as follows:
1. When payment is made in accordance with an assignment to a government agency or an assignment made pursuant to a court order; or
2. When payment is made to a business agent, such as a billing service or accounting firm, who renders statements and receives payment in the name of the contractor, noncontracting provider or nonprovider, providing that the agent's compensation for this service is:
   a. Reasonably related to the cost of processing the statements;
   b. Not dependent upon the actual collection of payment.

B. Payment to physicians, dentists or other health professionals may be made as follows:
1. To the employer of the physician, dentist or other health professional, if such person is required, as a condition of employment, to turn over fees to his or her employer;
2. To a foundation, plan, consortium or other similar organization, including a health care service organization, which furnishes health care through an organized health care delivery system, if there is a contractual arrangement between the organization and the person furnishing the services under which the organization bills or receives payment for such services.

C. Payments prohibited. Contractors, noncontracting providers or nonproviders are prohibited from assigning all or part of AHCCCS payments for covered services furnished to a member to any party other than the provider except as specified in this Section.

D. Prohibition of payments to factors. Payment for covered services furnished to a member by a contractor, noncontracting provider or nonprovider shall not be made to, or through a factor, either directly, or by virtue of a power of attorney given to the factor.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-704 adopted as an emergency now adopted and amended as a permanent rule effective August 30 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended subsection A., Paragraph 2. effective October 1, 1985 (Supp. 85-5).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-705. Payments by Contractors

A. Authorization. A contractor shall pay for all admissions and covered services rendered to its members if a covered service or an admission has been arranged by a contractor's agent or an employee, a subcontracting provider, or other individual acting on a contractor's behalf and if necessary authorization has been obtained. A contractor shall not require prior authorization for a medically necessary covered service provided during any prior period for which a contractor is responsible. A contractor is not required to pay a claim for a covered service that is submitted more than 6 months after the date of the service or more than 6 months after the date of eligibility posting, whichever is later, or that is submitted as a clean claim more than 12 months after the date of the service or more than 12 months after the date of eligibility posting, whichever is later.

B. Timeliness of provider claim payment.
1. A contractor shall reimburse, or provide written notice for a claim that is denied or reduced by a contractor, to a subcontracting provider for the provision of medically necessary health care services to a contractor's member, within the time period specified by the subcontract.
2. Unless the subcontract specifies otherwise, a contractor shall pay valid clean claims according to 42 U.S.C. 1396u-2, as of August 5, 1997, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments and states that:
   a. 90% of valid clean claims shall be paid within 30 days of the date of receipt of a claim,
   b. 99% of valid clean claims shall be paid within 90 days of the date of receipt of a claim, and
   c. The remaining 1% of valid clean claims shall be paid within 12 months of the date of receipt of a claim.
3. Unless the subcontract specifies otherwise, a contractor shall provide notice of a denial or a reduction of a claim for:
   a. 90% of the claims within 30 days of the date of receipt of a claim,
   b. 99% of the claims within 90 days of the date of receipt of a claim, and
   c. The remaining 1% of the claims within 12 months of the date of receipt of a claim.
4. A notice of denial or reduction shall include a statement describing the right to grieve the contractor's denial or reduction of a claim according to Article 8 of this Chapter.

C. Date of Claim. A contractor's date of receipt of an inpatient or an outpatient hospital claim shall be the date the claim is received by a contractor as indicated by the date stamp on the claim, the claim reference number, or the date-specific number system assigned by a contractor. A hospital claim shall be considered paid on the date indicated on the disbursement check. A denied hospital claim shall be considered adjudicated on the date of its denial. A claim that is pending for additional supporting documentation will receive a new date of receipt upon receipt of the additional documentation; however, a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01(J) or 36-2904(K), as applicable, will not receive a new date of receipt. A contractor and a hospital may, through a contract approved as specified in R9-22-715(A), adopt a method for identifying, tracking, and adjudicating a claim that is different from the method described in this subsection.

D. Payment for medically necessary outpatient hospital services.
1. A contractor shall reimburse a subcontracting and a noncontracting provider for the provision of outpatient hospital services rendered on or after March 1, 1993, at either a rate specified by a subcontract or, in absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges. Subcontract rates, terms, and conditions are subject to review, and

approval or disapproval under A.R.S. § 36-2904(K)(1)(b) and A.A.C. R9-22-715.

2. A contractor shall pay for all emergency care services rendered to a member by a noncontracting provider or a nonprovider when the services:
   a. Are rendered according to the prudent layperson standard,
   b. Conform to the definitions of emergency medical and acute mental health services in Articles 1 and 12, and
   c. Conform to the notification requirements in Article 2.

E. Payment for inpatient hospital services. A contractor shall reimburse an out-of-state hospital for the provision of hospital services at negotiated discounted rates, the Arizona average cost-to-charge ratio multiplied by covered charges or, if reasonably and promptly available, the Medicaid rate that is in effect at the time a service is provided in the state in which the hospital is located, whichever is lowest. A contractor shall reimburse an in-state subcontractor and a noncontracting provider for the provision of inpatient hospital services rendered with an admission date on or after March 1, 1993, at either a rate specified by a subcontract or, in absence of a subcontract, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and A.A.C. R9-22-712. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904(K)(1)(b) and A.A.C. R9-22-715. This subsection does not apply to a contractor participating in the pilot program described in R9-22-718.

F. Payment for observation days. A contractor may reimburse a subcontracting and a noncontracting provider for the provision of observation days at either a rate specified by a subcontract or, in the absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges.

G. Review of hospital claims.

1. If a contractor and a hospital do not agree on reimbursement levels, terms, and conditions, the reimbursement levels established under A.R.S. § 36-2903.01 and A.A.C. R9-22-712 or R9-22-718 shall apply. In these cases, a hospital shall obtain prior authorization from an appropriate contractor for nonemergency admissions. A contractor shall consider the medical condition of a member, length of stay, and other factors when issuing its prior authorization. A contractor shall not require prior authorization for medically necessary services provided during any prior period for which a contractor is responsible. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of the contract regarding utilization control activities. Failure to obtain prior authorization when it is required shall be cause for nonpayment or denial of a claim. A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and make a hospital's medical records, specific to a member enrolled with a contractor, available for review.
2. Regardless of prior authorization or concurrent review activities, all hospital claims, including outlier claims, are subject to prepayment medical review and post-payment review by a contractor. Post-payment reviews shall be consistent with A.R.S. § 36-2903.01(O), and an erroneously paid claim is subject to redeployment. If prior authorization was given for a specific level of care, but medical review of a claim indicates that a different level of care was appropriate, a contractor may adjust a claim to reflect the more appropriate level of care. An adjustment in level of care shall be effective on the date when the different level of care was medically appropriate.
3. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures different from those in this subsection if a subcontract binds both parties and meets the requirements of R9-22-715.

H. Timeliness of hospital claim payment. Payment by a contractor for inpatient hospital admissions and outpatient hospital services on and after March 1, 1993, shall be subject to Laws 1993, 2nd Special Session, Ch. 6, § 29, as amended by Laws 1995, 1st Special Session, Ch. 5, § 8; Laws 1993, 2nd Special Session, Ch. 6, § 27, as amended by Laws 1995, 1st Special Session, Ch. 5, § 6; and A.R.S. § 36-2903.01(J)(6).

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-705 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of the amended rule identical to emergency (Supp. 83-3). Former Section R9-22-705 repealed, new Section R9-22-705 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment adopted effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (C) effective October 1, 1987; amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended subsections (A) and (C) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1).

R9-22-706. Payments by the Administration for Services Provided to Eligible Persons

A. Payment for emergency and medically necessary non-hospital outpatient services. The Administration shall make payments as defined in R9-22-710 for emergency and medically necessary non-hospital services provided to eligible persons.

1. For dates of service on or before September 30, 1997, emergency services provided to the indigent, the medically needy, and eligible low-income children from the date of notification pursuant to R9-22-313 to the date of enrollment with a prepaid capitated contractor shall be paid at the capped fee-for-service rate or billed charges, whichever is lower. On the date of notification to the AHCCCS Administration, the county shall notify the AHCCCS Administration of the amount of medical expenses necessary to satisfy the spend down requirement of R9-22-321 and incurred by the household, if any, during the period of the Administration's retroactive liability.
2. For dates of service on or before September 30, 1997, medically necessary services provided to categorically

eligible persons and eligible assistance children from the effective date of eligibility to the date of enrollment with a prepaid capitated contractor shall be paid at the capped fee-for-service rate or billed charges, whichever is less.

B. Indian Health Service. The Administration shall pay IHS the all-inclusive inpatient, outpatient, or ambulatory surgery rates published in the *Federal Register* for AHCCCS-covered services provided in IHS facilities. Except as provided in R9-22-708, IHS medical service referrals for eligible Native Americans made to off-reservation contractors, providers, noncontracting providers, or nonproviders shall be prior authorized.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-706 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-706 repealed, new Section R9-22-706 adopted effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Amended as an emergency effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment adopted effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsections (A), (D), (E), (F), and (G) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (F) effective December 22, 1987 (Supp. 87-4). Amended subsections (A) and (F) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3).

R9-22-707. Payments for Newborns

If a mother is enrolled on the date of her newborn baby's birth, a contractor shall be financially liable under the mother's capitation to provide all AHCCCS-covered services to the newborn baby from the date of birth to the date of the mother's disenrollment or the date of the baby's enrollment, whichever occurs 1st. However, if the mother is eligible for AHCCCS as an indigent or medically needy individual, the contractor shall have a maximum liability of 60 days under the mother's capitation.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-707 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Repealed as a permanent action effective May 16, 1983 (Supp. 83-3). New Section R9-22-707 adopted effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Former Section R9-22-707 repealed, new Section R9-22-707 adopted effective October 1, 1985 (Supp. 85-5). Former Section R9-22-707 repealed, new Section R9-22-707 adopted effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3).

R9-22-708. Payment for services provided to eligible Native Americans residing on reservation

A. Categorically eligible Native Americans may enroll with a contractor in accordance with Article 3 of these rules.

B. Categorically eligible Native Americans who do not select an AHCCCS contractor and indigent and medically needy Native Americans shall be assigned in accordance with Article 3 of these rules.

C. Providers and nonproviders shall comply with prior authorization requirements of the Administration, as set forth in Article 2 of these rules, and of contractors.

D. Contractors other than the Indian Health Service providing care to eligible Native Americans shall be reimbursed on a capitation basis.

E. Once a Native American has enrolled with a contractor, no referral care rendered after the date of enrollment shall be reimbursable by a contractor unless the care is rendered pursuant to a referral or prior authorization made by the contractor of record.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-708 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-708 repealed, new Section R9-22-708 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-708 renumbered and amended as Section R9-22-709, new Section R9-22-708 adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-709. Contractor's Liability to Hospitals for the Provision of Emergency and Subsequent Care

A. For purposes of program and contractor liability, an emergency medical or acute mental health condition of a member shall be subject to reimbursement only until the member's condition is stabilized and the member is transferable, or until the member is discharged following stabilization subject to the requirements of A.R.S. § 36-2909(E) and Article 2 of these rules.

B. Subject to subsection (A), if a member cannot be transferred following stabilization to a facility that has a subcontract with the contractor of record, the contractor of record shall pay for all appropriately documented, prior authorized, and medically necessary treatment provided the member before the date of discharge or transfer in accordance with payment standards in R9-22-705.

C. If a member refuses transfer from a nonprovider or noncontracting hospital to a hospital affiliated with the member's contractor of record, neither the Administration nor the contractor shall be liable for any costs incurred after the date of refusal if:

1. After consultation with the member's contractor of record, the member continues to refuse the transfer; and

2. The member has been provided and signs a written statement, before the date of transfer of liability, informing the member of the medical and financial consequences of refusing to transfer. If the member refuses to sign a written statement, a statement signed by 2 witnesses indicating that the member was informed may be substituted.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-709 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-709 repealed, new Section R9-22-709 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-709 renumbered and amended as Section R9-22-713, former Section R9-22-708 renumbered and amended as Section R9-22-709 effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective September 22, 1997 (Supp. 97-3).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-710. Capped Fee-for-service Payments for Non-hospital Services

A. Service codes. The Administration shall maintain a current copy of the following code manuals at the central office of the Administration for reference use during customary business hours:
1. The Physicians' Current Procedural Terminology (CPT) and Health Care Financing Administration Common Procedure Coding System (HCPCS). These manuals identify medical services and procedures performed by physicians and other providers.
2. The AHCCCS Transportation, Supply, Equipment, and Appliance codes. These codes identify applicable services or supplied items.
3. The International Classification of Diseases.
4. Nationally recognized pharmacy coding manual.

B. Fee schedule. The Administration shall pay providers, including noncontracting providers, at the lesser of billed charges or the capped fee-for-service rates specified in subsections (B)(1) through (5) unless a different fee is specified by contract between the Administration and the provider, or is otherwise required by law. The Administration shall provide notice of changes in methods and standards for setting payment rates for services in accordance with 42 CFR 447.205, effective December 19, 1983, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
1. Physician services. Fee schedules for payment for physicians services are on file at the central office of the Administration for reference use during customary business hours.
2. Pharmacy services. Fee schedules for payment for pharmacy services are exempt from rulemaking procedures under A.R.S. § 41-1005, but are subject to 42 CFR 447.331 through 447.332, effective July 31, 1987, which is incorporated by reference and on file with the Administration and the Office of Secretary of State. These incorporations by reference contain no further editions or amendments.
3. Dental services. Fee schedules for payment for dental services are on file at the central office of the Administration for reference use during customary business hours.
4. Transportation services:
   a. Ground ambulance services. Fee schedules for payment for ambulance services are on file at the central office of the Administration for reference use during customary business hours. For ambulance providers that have charges established by the Arizona Department of Health Services (ADHS), the fee schedule amount is 80% of the ambulance provider's ADHS-approved fees for covered services. For ambulance providers whose fees are not established by ADHS, the fee schedule amount is 80% of the ambulance provider's billed charges or the capped fee-for-service amount for covered services, whichever is less.
   b. Air ambulance services. Fee schedules for payment for air ambulance services are on file at the central office of the Administration for reference use during customary business hours.
   c. Nonambulance services. Fee schedules for payment for nonambulance services are on file at the central office of the Administration for reference use during customary business hours.
5. Medical equipment. Fee schedules for payment for medical equipment are on file at the central office of the Administration for reference use during customary business hours. The Administration shall reimburse providers once for durable medical equipment (DME) during any 2-year period, unless the Administration determines that DME replacement within that period is medically necessary for the member. Unless authorized by the Administration, no more than 1 repair and adjustment shall be reimbursed during any 2-year period.

C. Capped fee-for-service medical cost pool and payment. The Administration may establish a capped fee-for-service medical cost pool for each county in which there are capped fee-for-service physician contractors. The Administration shall pay all physician fees out of this pool. Fifteen percent of allowable physician fees shall be withheld in the pool. At the end of a contract period, the Administration shall divide any surplus or deficit remaining in the pool evenly between the Administration and the participating physicians subject to the following:
1. The physician withhold shall be used to offset the physician portion of any deficit. Physicians shall not be responsible for any deficit greater than the aggregate amount withheld. The Administration shall return all withholds not needed to fund a deficit on a pro rata basis.
2. The Administration shall divide the physician portion of any surplus so 2/3 goes to primary care physicians and 1/3 to referral physicians. These portions shall be divided pro rata among the physicians in each category subject to an upper limit. The physician portion of any surplus is limited so referral physicians receive no more than 115% of the Administration's maximum allowable fees for their services and primary care physicians receive no more than 130%.

D. Distribution of funds. The Administration shall make annual settlements of the medical cost pool on an incurred basis. The Administration shall estimate incurred medical costs for a contract period for settlement purposes when 3 full months of paid

claim data can be summarized following the end of the contract period. The settlement shall occur within 105 days following the end of the contract period.

E. The Administration reserves the right to adjust the percentage of withholding for any individual physician whose utilization rates are deemed to be excessive based on historical physician profiles.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-710 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of amended rule identical to emergency (Supp. 83-3). Former Section R9-22-710 repealed, new Section R9-22-710 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985. The capped fee-for-service schedules, deleted from Section R9-22-710, are now on file at the central office of the Administration (Supp. 85-5). Amended subsections (B) through (D) effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective July 1, 1988 (Supp. 88-3). Amended subsection (B) effective April 27, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-711. Copayments

A. Contractors shall be responsible for collecting copayments from members. The following are excluded from copayment requirements:
1. Prenatal care including all obstetrical visits;
2. Well-baby, EPSDT care;
3. Care in nursing facilities and intermediate care facilities for the mentally retarded;
4. Visits scheduled by a primary care physician or practitioner, and not at the request of a member; and
5. Drugs and medications beginning October 1, 1985.

B. Except as provided in subsection (A), contractors and members shall comply with the following copayment schedules:
1. Categorically eligible members:

Covered Services	*Copayment*
Doctor's office or home visit and all diagnostic and rehabilitative x-ray and laboratory services associated with the visit.	$1.00 per visit
Nonemergency surgery	$5.00 per procedure
Nonemergency use of the emergency room	$5.00 per visit

2. Indigent, medically needy, eligible assistance children, and eligible low-income children members:

Covered Services	*Copayment*
Doctor's office or home visit and all diagnostic and laboratory services associated with the visit.	$5.00 per visit
Nonemergency surgery	$5.00 per procedure
Nonemergency use of the emergency room	$5.00 per visit

C. A contractor shall ensure that a member is not denied services because of the member's inability to pay a copayment.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Sections R9-22-711 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-711 repealed, new Section R9-22-711 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-712. Payments by the Administration for Hospital Services

A. Inpatient hospital reimbursement. The Administration shall pay for covered inpatient acute care hospital services provided to eligible persons with admissions on and after March 1, 1993, on a prospective reimbursement basis. The prospective rates shall represent payment in full, excluding quick-pay discounts, slow-pay penalties, noncategorical discounts, and third-party payments for both accommodation and ancillary department services. The rates shall include reimbursement for operating, capital, and medical education costs, as applicable. The Administration shall classify each AHCCCS inpatient hospital day of care into 1 of several tiers appropriate to the services rendered for payment purposes. The rate for a particular tier is referred to as the tiered per diem rate of reimbursement. Until the time of rebasing, as described in this Section, the number of tiers is 7 and the maximum number of tiers payable per continuous stay is 2. Payment of outlier or transplant claims or payment to out-of-state hospitals, freestanding psychiatric hospitals, rehabilitation hospitals, and other specialty facilities may differ from the inpatient hospital tiered per diem rates of reimbursement described in this Section.
1. Tier rate data. To calculate the tiered per diem rates for the initial prospective year, the Administration shall use Medicare Cost Reports for Arizona hospitals for fiscal years ending in 1990 and a database consisting of inpatient hospital claims and encounters for each hospital with beginning dates of service for the period November 1, 1990, through October 31, 1991.

a. Medicare Cost Report data. Because Medicare Cost Report years are not standard among hospitals and were not audited at the time of the rate calculation for the initial prospective rate year, the Administration shall inflate all the costs to a common point in time as described in subsection (A)(2) for each component of the tiered per diem rates. The Administration shall not make any changes to the tiered per diem rates if the Medicare Cost Report data are subsequently updated or adjusted. If a single Medicare Cost Report is filed for more than 1 hospital, the Administration shall allocate the costs to each of the respective hospitals. Hospitals shall submit information to assist the Administration in this allocation.

b. Claim and encounter data. For the database, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the database was developed under A.R.S. § 36-2903.01(J). The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude claims and encounters that fail these edits from the database. The Administration may make adjustments to the data as required to correct errors. The Administration shall also exclude from the database, the following claims and encounters:

i. Those missing information necessary for the rate calculation,

ii. Medicare crossovers,

iii. Those submitted by freestanding psychiatric hospitals, and

iv. Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered per diem rate.

2. Tier rate components. The Administration shall establish inpatient hospital prospective tiered per diem rates based on the sum of the following 3 components: operating, capital, and medical education. The rate for the operating component shall be a statewide rate for each tier except for the ICU tier which is based on peer groups. The rate for the medical education component shall be hospital-specific. The rate for the capital component shall be a blend of statewide and hospital-specific values based upon a sliding scale until October 1, 2002. The Administration shall not include the medical education component in the tiered per diem rates if direct medical education payments are made under subsection (A)(12). The Administration shall use the following methodologies to establish the rates for each of these components and to calculate the statewide inpatient cost-to-charge ratio used for payment of outliers and out-of-state hospitals.

a. Operating component. Using the Medicare Cost Reports and the claim and encounter database, the rate for the operating component shall be computed as follows:

i. Data preparation. The Administration shall identify and group into department categories, the Medicare Cost Report data that provide ancillary department cost-to-charge ratios and accommodation costs per day. To comply with federal regulation, 42 CFR 447.271, the Administration shall limit cost-to-charge ratios to 1.00 for each ancillary department.

ii. Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter database for all hospitals. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the departments in which the line items on the Medicare Cost Reports have been grouped. The ancillary department cost-to-charge ratios for a particular hospital shall be multiplied by the covered ancillary department charges on each of the hospital's claims and encounters. The AHCCCS inpatient days of care on the particular hospital's claims and encounters shall be multiplied by the corresponding accommodation costs per day from the hospital's Medicare Cost Report. The ancillary cost-to-charge ratios and accommodation costs per day shall exclude medical education and capital costs. The Administration shall inflate the resulting operating costs for the claims and encounters of each hospital to a common point in time, December 31, 1991, using the DRI inflation factor and shall reduce the operating costs for the hospital by an audit adjustment factor based on available national data and Arizona historical experience in adjustments to Medicare reimbursable costs.

iii. Operating cost tier assignment. After calculating the operating costs, the Administration shall assign the claims and encounters used in the calculation to tiers based on diagnosis, procedure, or revenue codes, or NICU classification level, or a combination of these items. For the ICU tier, claims and encounters shall be further assigned to the urban or rural peer group. The tier rate for NICU Level II shall be calculated as 75% of the NICU Level III tier rate. For claims and encounters assigned to more than 1 tier, ancillary department costs shall be allocated to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component of the tiered per diem rates, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (A)(6).

iv. Operating rate calculation. The rate for the operating component for each tier shall be set by dividing total statewide or peer group hospital costs identified in subsection (A)(2)(a) within the tier by the total number of AHCCCS inpatient hospital days of care reflected in the claim and encounter database for that tier.

b. Medical education component.

i. Calculation of medical education costs and component rate. The Administration shall calculate the rate for the medical education component of the tiered per diem rate on a hospital-specific basis by identifying the total direct medical education costs listed on the hospital's Medicare Cost Report. The medical education costs identified for each hospital shall reflect the medical education costs incurred by all the payors for the hospital's services, including AHCCCS. The Administration shall reduce the

medical education costs for each hospital by an audit adjustment factor based on available national data and Arizona experience in adjustments to Medicare reimbursable costs. The Administration shall divide the hospital's reduced medical education costs by the hospital's total inpatient days for all patients to yield the rate for the medical education component of the tiered per diem rate. The Administration shall inflate the medical education component to a common point in time, December 31, 1991, using the DRI inflation factor.

ii. Indexing medical education component to tiers. The Administration shall index the rate for the medical education component for each tier by the relative weighting of that tier's operating component to the operating component of all tiers. The relative weighting factor for each of the hospital's tiers shall be calculated by dividing each tier's operating component rate by the weighted average operating component rate for all tiers. The weighted average operating component rate is calculated by multiplying the operating component rate for each tier by the number of AHCCCS inpatient hospital days of care for each tier. The total of these products is then divided by the total number of AHCCCS inpatient hospital days of care for all tiers. The relative weighting factor for a tier's medical education component is multiplied by the medical education component to determine the medical education component rate for the particular tier.

iii. New medical education programs. The tiered per diem rates for hospitals with new medical education programs that are not reflected on the Medicare Cost Reports used to establish rates under this Section shall not include a medical education component until the Medicare Cost Reports used in rebasing reflect the costs of the new medical education programs. New medical education programs may be recognized prior to a rebase year at the discretion of the Director. If a hospital has an existing medical education program that is reflected in its Medicare Cost Report but has added a new medical education program that is not reflected, the hospital's tiered per diem rates shall include a rate for the medical education component that reflects only those medical education costs included in the Medicare Cost Report.

c. Capital component.

i. Structure of the capital component. During the 10-year period beginning with the initial prospective rate year, the rate for the capital component of the tiered per diem rate shall represent a blend of statewide and individual hospital capital costs in accordance with A.R.S. § 36-2903.01(J)(9). After September 30, 2002, the Administration shall combine the rate for the capital component with the rate for the operating component to produce a single statewide rate for the combination of the capital and operating components.

ii. Calculation of statewide capital costs and statewide capital component rate. The capital costs associated with inpatient hospital care shall be calculated in a manner similar to that described for operating costs in subsection (A)(2)(a)(ii). Because of the way costs are reported on the Medicare Cost Report, capital costs are derived by subtracting the costs determined when the ancillary department cost-to-charge ratios and the accommodation costs per day include only operating costs and medical education costs from the costs determined when the ancillary department cost-to-charge ratios and accommodation costs per day include capital costs as well as operating costs and medical education costs. The Administration shall inflate the resulting capital costs for each hospital to December 31, 1991, using the DRI inflation factor and shall reduce the capital costs for each hospital by an audit adjustment factor based on available national data and Arizona experience in adjustments to Medicare reimbursable costs. The statewide per day rate for capital costs shall be calculated by dividing the resulting total capital costs for all hospitals by the total AHCCCS inpatient hospital days of care reflected in the claim and encounter database.

iii. Computation of hospital-specific capital costs and hospital-specific capital component rates. The Administration shall calculate the hospital-specific capital costs per day for each hospital by dividing the capital costs identified for each hospital in subsection (A)(2)(c)(ii), as adjusted by the audit factor and inflated to December 31, 1991, by the AHCCCS inpatient hospital days of care for that hospital reflected in the claim and encounter database.

iv. Blending of capital rates. The Administration shall set the rate for the capital component by blending of the statewide and hospital-specific capital rates in accordance with the following schedule:

PROSPECTIVE RATE YEAR	HOSPITAL SPECIFIC	STATE-WIDE
3/1/93-9/30/94	90%	10%
10/1/94-9/30/95	80%	20%
10/1/95-9/30/96	70%	30%
10/1/96-9/30/97	60%	40%
10/1/97-9/30/98	50%	50%
10/1/98-9/30/99	40%	60%
10/1/99-9/30/00	30%	70%
10/1/00-9/30/01	20%	80%
10/1/01-9/30/02	10%	90%
On and after-10/01/02	0%	100%

v. Because the rate for the capital component is a blend of the statewide and hospital-specific costs, the capital component shall not be further inflated to the mid-point of the initial prospective rate year.

vi. Indexing capital component to tiers. The Administration shall index the rate for the capital component for each tier by the relative weighting of that tier's operating component to the operating component of all tiers. The relative weighting factor for each of the hospital's tiers shall be calculated by dividing each tier's operating component rate by the weighted average operating component rate for all tiers. The

weighted average operating component rate is calculated by multiplying the operating component rate for each tier by the number of AHCCCS inpatient hospital days of care for each tier. The total of these products is then divided by the total number of AHCCCS inpatient hospital days of care for all tiers. The relative weighting factor for a tier's capital component is multiplied by the capital component to determine the capital component rate for the particular tier.

d. Statewide inpatient hospital cost-to-charge ratio. The statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, under subsection (A)(6). The Administration shall calculate the AHCCCS statewide inpatient hospital cost-to-charge ratio by using the Medicare Cost Report data and claim and encounter database described in subsection (A)(1) and used to determine the initial tiered per diem rates. For each hospital, the covered accommodation days on the claims and encounters shall be multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters shall be multiplied by the ancillary department cost-to-charge ratios. The accommodation costs per day and the ancillary department cost-to-charge ratios for each hospital shall be determined in the same way as described in subsection (A)(2)(a) but shall include costs for operating, capital, and medical education. The Administration shall then calculate the statewide inpatient hospital cost-to-charge ratio by summing the covered accommodation costs and ancillary department costs from the claims and encounters for all hospitals and dividing by the sum of the total covered charges for these services for all hospitals.

e. Unassigned tiered per diem rates. In the case of a hospital for which no tiered per diem rate is assigned to a tier, the Administration shall pay the statewide rate for the operating component of that tier if the hospital has qualifying claims and encounters subsequent to the base year. The rates for the capital and medical education components of a tiered per diem rate, if applicable, shall be re-weighted for a tier to which no tiered per diem rate is assigned as described in subsections (A)(2)(b) and (A)(2)(c).

3. Tier assignment. The Administration shall assign AHCCCS inpatient hospital days of care to tiers based on information submitted on the inpatient hospital claim or encounter including diagnosis, procedure or revenue codes, peer group, or NICU classification level or a combination of these items.

a. Tier hierarchy. Assignment of AHCCCS inpatient hospital days of care to a tier shall follow an ordered, hierarchical processing, as defined on the Hierarchy for Tier Assignment, which is included in subsection (J). Claims for inpatient hospital services must meet medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than 2 tiers, regardless of the number of interim claims that is submitted by the hospital. If a hospital changes its designation under Medicare from a rural to an urban hospital, or visa versa, the Administration shall continue to assign claims from that hospital to the rural ICU tiered per diem rate, or visa versa, until the tiered per diem rates are rebased.

b. Tier exclusions. The Administration shall not assign or pay AHCCCS inpatient hospital days of care that do not occur during an individual's eligibility period. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital cost-to-charge ratio multiplied by ancillary department and accommodation charges.

c. Seven tiers. The following 7 tiers shall be in effect until the time of rebasing:

i. Maternity. The maternity tier shall be identified by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the AHCCCS inpatient hospital days of care on the claim shall be paid the maternity tiered per diem rate.

ii. NICU. The NICU tier shall be identified by a revenue code. For a hospital to qualify for the NICU tiered per diem rate, the hospital must be classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. Among AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier, those with an NICU revenue code shall be paid at the NICU tiered per diem rate. Any remaining AHCCCS inpatient hospital day or days on the claim not meeting NICU Level II or NICU Level III medical review criteria shall be paid at the nursery tiered per diem rate.

iii. ICU. The ICU tier shall be identified by a revenue code. Among AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the ICU tier, those with an ICU revenue code shall be paid at the ICU tiered per diem rate. If there are any AHCCCS inpatient hospital days on the claim without an ICU revenue code, they may be classified as surgery, psychiatric, or routine tiers.

iv. Surgery. The surgery tier shall be identified by a revenue code in combination with a valid surgical procedure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list shall identify minor procedures such as sutures that do not require the same hospital resources as other procedures. A surgery claim may also have AHCCCS inpatient hospital days of care at the ICU tier. AHCCCS shall pay the surgery tier only when the surgery occurs on a date during which the member is eligible.

v. Psychiatric. The psychiatric tier shall be identified by either: a psychiatric revenue code and a psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. A claim with AHCCCS inpatient hospital days of care in the psychiatric tier may split only with the ICU tier.

vi. Nursery. The nursery tier rate shall be identified by a revenue code. A claim with AHCCCS inpatient hospital days of care in the nursery tier may split only with the NICU tier.

vii. Routine. The routine tier shall be identified by particular revenue codes and shall include AHCCCS inpatient hospital days of care that are not otherwise classified into the proceeding tiers or paid in accordance with subsection (A)(11). The routine tier may split only with the ICU tier.

4. Annual update. After the initial prospective rate year and between rebasing years, the Administration shall annually update the inpatient hospital tiered per diem rates in accordance with A.R.S. § 36-2903.01(J)(2) and (J)(9) as follows:
   a. Inflation factor. The rates for the operating and medical education components of the tiered per diem rate shall be inflated to the midpoint of the prospective rate year, using the DRI inflation factor.
   b. Length of stay adjustment. The rate for the operating component of the tiered per diem rate shall be adjusted for any change in the statewide average length of stay for eligible persons. The change in length of stay shall be computed each year by comparing the average length of stay for each tier based on claims and encounters to the average length of stay for each tier calculated in the previous year. The operating component of the tiered per diem rates shall be adjusted by the percentage change in length of stay. If the length of stay increases for a tier, the rate for the operating component shall be adjusted downward. If the length of stay decreases for a tier, the rate for the operating component shall be adjusted upward. Except for the 1st annual update of the initial prospective rate year, the Administration shall use claims and encounters that are from the federal fiscal year period beginning 2 years before the prospective rate year that is being updated. For the annual update for the prospective rate year beginning October 1, 1996, the claims and encounters with beginning dates of service from October 1, 1994, to September 30, 1995 shall be used for making any length of stay adjustment. For the annual update of the initial prospective rate year, the Administration shall use claims and encounters with beginning dates of service from March 1, 1993, to September 30, 1993. The Administration shall subject the claim and encounter data to the same data edits described in subsection (A)(1)(b). Outliers shall be excluded as identified in subsection (A)(6)(a).
   c. Capital component update. For the capital component of the tiered per diem rate, the Administration shall adjust the hospital-specific and statewide average blend described in subsection (A)(2)(c). The Administration shall adjust the hospital-specific part of the capital component by using the capital costs from the hospital's subsequent Medicare Cost Report. The Medicare Cost Report used for the 1st update is FY1991. The percentage change in the capital costs per day, as shown on the hospital's Medicare Cost Report from one year to the next, shall be applied to the hospital-specific part of the capital component. The Administration shall recalculate the statewide average part of the capital component based on the percentage change in hospital-specific capital costs. The percentage change shall be limited to the initial prospective rate year statewide capital costs increased by the DRI inflation factor. The Administration shall adjust the rate for the capital component of the tiered per diem downward, if after the update, the statewide average rate of the capital component as a percent of the statewide average total tiered per diem rate exceeds the percentage of the statewide average capital costs to the total statewide average inpatient hospital costs used in calculating the tiered per diem rates for the initial prospective rate year.
5. New Hospitals. The Administration shall calculate the tiered per diem rates for new hospitals differently than the tiered per diem rates for hospitals for which Medicare Cost Reports and claims and encounters were used to establish the tiered per diem rates for the initial prospective rate year or for a rebase year. The tiered per diem rates paid to a new hospital shall be the sum of the operating and capital components. The rate for the operating component for a new hospital shall be the same as the rate for the operating component established in subsection (A)(2)(a). The rate for the capital component for a new hospital shall equal the statewide average rate for the capital component as described in subsection (A)(2)(c)(ii) and shall vary by tier based on an index that represents the statewide relative weight of each tier's operating component to the operating component of all tiers. The tiered per diem rates for new hospitals shall not include a medical education component. The annual update shall be applied to a new hospital's rates for its operating and capital components, except hospital-specific capital costs shall not be considered as described in subsection (A)(2)(c)(iii).
6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers in accordance with this Section by multiplying the cover charges on a claim by the statewide inpatient hospital cost-to-charge ratio.
   a. Outlier criteria. For the initial prospective rate year, the Administration shall set the statewide outlier cost threshold for each tier at the greater of 3 standard deviations from the statewide mean operating cost per day within the tier, or 2 standard deviations from the statewide mean operating cost per day across all the tiers. Because hospitals submit charges, rather than costs, on claims and encounters, the Administration sets hospital-specific charge thresholds by dividing the statewide outlier cost threshold for each tier by the hospital's inpatient operating cost-to-charge ratio. If the covered charges per day on a claim or encounter exceed the hospital-specific charge threshold for a tier, the claim or encounter shall be considered an outlier. If there are 2 tiers on a claim or encounter, the Administration shall determine whether the claim or encounter is an outlier by using a weighted threshold for the 2 tiers. The weighted threshold is calculated by multiplying each tier rate by the number of AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital.
   b. Update. The Administration shall update the outlier cost thresholds and outlier charge thresholds for each hospital. The outlier cost thresholds are

updated annually by recalculating the standard deviations based on the claims and encounters used for the length-of-stay adjustment described in subsection (A)(4)(b). The outlier charge thresholds are updated as defined in subsection (A)(6)(a). Claims and encounters exceeding the updated outlier cost thresholds will be excluded for purposes of calculating the change in length-of-stay. The Administration shall estimate the operating cost of claims and encounters based on the application of an inpatient hospital-specific operating cost-to-charge ratio.

7. Transplants. The Administration shall reimburse hospitals for an AHCCCS inpatient stay in which a covered organ transplant is performed through the terms of a relevant contract agreement. Pursuant to R9-22-716, if the Administration and a hospital that performs a transplant surgery on an eligible person do not have a contracted rate, the system shall not reimburse the hospital more than the contracted rate established by the Administration.
8. Rebasing. The Administration shall rebase the tiered per diem rates by the prospective rate year beginning October 1, 1998. The rebasing process shall include the following:
   a. Rebasing data. The Administration shall use a hospital's Medicare Cost Report for a fiscal year ending at least 2 years before the prospective rate year in which the rebase is to begin. For example, for the rebase year of October 1, 1998, the Medicare Cost Reports would be for hospital fiscal years ending in 1996, or earlier. The Administration shall follow the procedures described in subsection (A)(1)(a) for Medicare Cost Report data, except that costs shall be inflated to December 31 of the fiscal year applicable to the Medicare Cost Report year, and a new audit factor shall be derived by the Administration based on available national and Arizona data. To calculate the rebased tiered per diem rates, the Administration may use the ancillary department or line item cost-to-charge ratios from the Medicare Cost Report. In addition for each hospital, the Administration shall use a database consisting of inpatient hospital claims and, if appropriate, encounters with beginning dates of service covered by the hospital's respective Medicare Cost Report reporting period. Claims and encounters included in the database will be those available at the time of rebasing that pass the Administration's data quality, reasonableness, and integrity edits described in subsection (A)(1)(b). The Administration shall exclude or adjust the claims or encounters that do not meet the medical review criteria at R9-22-717 and R9-22-209(C).
   b. Rebasing components. The rebased tiered per diem rates shall include rates for the following 2 components: operating and capital. The Medical education component shall be included unless direct medical education is reimbursed under subsection (A)(12). The Administration shall follow the methodology described in subsection (A)(2) to establish the rebased rates for each of the components. However, during the rebasing process the Administration shall re-examine the current tier structure and may adopt an alternative structure, hierarchy, or number of tiers if analyses conducted by the Administration indicate that an alternative or alternatives is or are appropriate. The Administration shall add cost containment features at the time of rebasing.
   c. Rebasing peer groups for the operating component. To rebase the rate for the operating component of the tiered per diem rate, the Administration shall re-analyze whether the operating component shall be peer grouped according to such factors as geographical location or major teaching versus non-major teaching hospital.
   d. Rebasing the capital component. The capital component of the tiered per diem rate shall be a blend of statewide and hospital-specific capital costs pursuant to subsection (A)(2)(c). The Administration shall adjust the rate for the capital component of the tiered per diem rate downward if after rebasing the statewide average rate for the capital component as a percent of the statewide average total tiered per diem rate exceeds:
      i. The percentage of the statewide average capital costs to the total statewide average inpatient hospital costs used in calculating the tiered per diem rates for the initial prospective rate year; or
      ii. The most recently available national average percentage of capital costs to total inpatient hospital costs.
      iii. The adjustment to the rate for the capital component shall be based on the lesser of subsection (i) or (ii).
   e. Rebasing outliers. Depending on the payment methodology adopted at the time of rebasing, the Administration may not include provisions for payment of outliers.
   f. Psychiatric and rehabilitation hospitals. At the time of rebasing, the Administration shall re-examine the basis of payment for freestanding rehabilitation and psychiatric hospitals. If the decision is made to continue to reimburse these hospitals according to the methodology described in subsection (A)(10), the Administration shall exclude the claims and encounters from these hospitals that are not paid by the tiered per diem reimbursement system.
   g. Data required. Beginning with fiscal years ending in 1996, hospitals shall file with the Administration all Medicaid-specific schedules of the Medicare Cost Report at the time the Medicare Cost Report is submitted to the Medicare Intermediary as required in A.R.S. § 36-125.04.
9. Ownership change. A hospital shall not receive a change in any of the components of the hospital's tiered per diem rates upon an ownership change.
10. Psychiatric and rehabilitation hospitals. The Administration shall pay freestanding psychiatric hospitals an all-inclusive per diem rate based on the contracted rates used by the Department of Health Services and shall pay freestanding rehabilitation hospitals the rate for the operating component of the routine tiered per diem rate plus the rates for the capital and medical education components as appropriate or an all-inclusive per diem rate that is negotiated by the Administration.
11. Specialty facilities. The Administration may negotiate, at any time, reimbursement rates for inpatient specialty facilities or inpatient hospital services not otherwise addressed in this Section as provided by A.R.S. § 36-2903.01(J)(1).
12. Direct medical education payments. Instead of including a direct medical education component in the tiered per diem rates, the Administration may reimburse hospitals

directly for the hospital's costs associated with direct medical education. In this case, the Administration shall not continue to calculate direct medical education costs using the methodology described in subsection (A)(2)(b)(i), and shall not update direct medical education payments in accordance with subsection (A)(4).

B. Outpatient hospital reimbursement. The Administration shall pay for covered outpatient hospital services provided to eligible persons on and after March 1, 1993, at the AHCCCS outpatient hospital cost-to-charge ratio, multiplied by the covered charges.

1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs shall be included in the computation but outpatient medical education costs that are included in the inpatient medical education component shall be excluded. To calculate the outpatient hospital cost-to-charge ratio for the initial prospective rate year for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in subsections (A)(1)(a) and (A)(1)(b). The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:
   a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters for outpatient hospital services. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
   b. Cost-to-charge limit. To comply with federal regulation, 42 CFR 447.325, the Administration may limit cost-to-charge ratios at 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are noncovered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.
2. New hospitals. The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost-to-charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in specialty facilities.
4. Reimbursement requirements. To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than 0. The Administration shall not reimburse hospitals for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis, as described in subsection (B), if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation, or other outpatient department. The emergency room, observation, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment.
5. Rebasing. The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every 1 to 4 years using updated Medicare Cost Reports and claim and encounter data.

C. Discounts and penalties. The Administration shall subject all inpatient hospital admissions and outpatient hospital services on and after March 1, 1993, to quick-pay discounts and slow-pay penalties in accordance with Laws 1992, Ch. 302, §14, as amended by Laws 1993, 2nd S.S., Ch. 6, § 27; Laws 1995, 1st S.S., Ch. 5, § 6 and A.R.S. § 36-2903.01(J)(6).

D. Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall not withhold access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or its designated representative in performance of the Administration's utilization control activities. Failure to cooperate may result in denial or non-payment of claims.

E. Prior authorization. Failure to obtain prior authorization required by R9-22-210 shall be cause for denial or nonpayment of claims.

F. Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers to prepayment medical review, or post-payment review or both by the Administration. Post-payment reviews shall be consistent with A.R.S. § 36-2903.01(O) and erroneously paid claims are subject to recoupment. If prior authorization was given for a specific level of care but medical review of the claim indicates that a different level of care was appropriate, the Administration may adjust the claim to reflect the more appropriate level of care, which shall be effective on the date when the different level of care was medically appropriate.

G. Claim receipt. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the claim reference number. Hospital claims will be considered paid on the date indicated on disbursement checks. Denied claims will be considered adjudicated on the date of their denial. Claims that are denied and are resubmitted will receive new date stamps. Claims that are pending for additional supporting documentation from hospitals will receive new date stamps upon receipt of the additional documentation, except as provided under R9-22-717. Claims that pend for additional supporting documentation shall not be counted in the calculation of the quick-pay discounts and slow-pay penalties pursuant to R9-22-712 (C). For purposes of this subsection, the time-frames for submitting claims and the definition of a clean claim are consistent with A.R.S. § 36-2904.

H. Out-of-state hospital payments. The Administration shall pay for covered hospital services provided to eligible persons by out-of-state hospitals at negotiated discounted rates, the statewide average inpatient or outpatient cost-to-charge ratio multi-

plied by covered charges or, if reasonably and promptly available, the Medicaid rate that is in effect at the time services are provided in the state in which the hospital is located, whichever is lowest.

I. Prior period payments. The Administration shall pay for covered hospital services, provided to eligible persons with inpatient hospital admissions and outpatient hospital services before March 1, 1993, pursuant to R9-22-706.

J. Hierarchy For Tier Assignment.

TIER	IDENTIFICATION CRITERIA	ALLOWED SPLITS
MATERNITY	A primary diagnosis defined as maternity 640.xx - 643.xx, 644.2x - 676.xx, v22.xx - v24.xx or v27.xx.	None
NICU	Revenue Code of 175 for DOS before 10/1/95 AND the provider has a Level II or Level III NICU, or Revenue Code of 174 for DOS on, or after 10/1/95 AND the provider has a Level II or Level III NICU.	Nursery
ICU	Revenue Codes of 200-204, 207-212, or 219.	Surgery Psychiatric Routine
SURGERY	Surgery is identified by a revenue code of 36x. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list.	ICU
PSYCHIATRIC	Psychiatric Revenue Codes of 114, 124, 134, 144, or 154 AND Psychiatric Diagnosis = 290.xx - 316.xx. If a routine revenue code is present and all diagnoses codes on the claim are equal to 290.xx - 316.xx, classify as a psychiatric claim.	ICU
NURSERY	Revenue Code of 17x, not equal to 175 or 174.	NICU
ROUTINE	Revenue Codes of 100 - 101, 110-113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16x, 206, 213, or 214.	ICU

Historical Note

Adopted as an emergency effective February 23, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to emergency (Supp. 83-3). Former Section R9-22-712 repealed, new Section R9-22-712 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-712 renumbered and amended as Section R9-22-1001 effective October 1, 1985 (Supp. 85-5). New Section R9-22-712 adopted under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective January 14, 1997 (Supp. 97-1).

R9-22-713. Payments made on behalf of a contractor; recovery of indebtedness

A. The Administration may make payments on behalf of a contractor in order to prevent a suspension or termination of AHCCCS services when either:

1. No payment period is specified by subcontract and a valid accrued claim is not paid within 60 days of receipt by such contractor, or
2. A valid accrued claim is not paid within the period set forth under subcontract.

B. In the event a payment is made by the Administration pursuant to this Article, the Administration shall reduce the capitation payment due a contractor by the amount of payment made, plus a ten percent administrative fee for each claim that is paid.

C. If a contractor or a subcontracting provider receives an overpayment or otherwise becomes indebted to the Administration, the contractor or subcontracting provider shall immediately remit such funds to the Administration for deposit in the AHCCCS fund.

D. The action of the Administration to recover amounts from contractors or subcontracting providers may include the following:

1. Negotiation of a repayment agreement executed with the Administration.
2. Withholding or offsetting against current or future prepayments or other payments to be paid to the contractor or subcontracting provider.
3. Enforcement of, or collection against, the performance bond or withhold described in R9-22-701, subsection (C).

E. Except as specifically provided for in these rules, the Administration shall not be liable for payment for medical expenses incurred by enrolled members of prepaid capitated contractors.

Historical Note

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to the emergency (Supp. 83-3). Former Section R9-22-713 repealed, new Section R9-22-713 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-713 renumbered and amended as Section R9-22-714, former Section R9-22-709 renumbered and amended as Section R9-22-713 effective October 1, 1985 (Supp. 85-5).

R9-22-714. Contractor risk retention fund (AHCCCS-assembled networks)

Contractor risk pools may be established by the Administration for AHCCCS-assembled networks as follows:

1. Fifteen percent of the total capitation to be paid to primary care contractors may be retained by the Administration. If the Administration determines to do so, to prevent over utilization or other misuse of the system, ten percent shall be deposited into an inpatient risk pool fund and five percent shall be deposited into a specialty care risk pool fund. Hospital utilization and the frequency of referrals shall be monitored on a monthly basis to compare actual utilization experience with targeted utilization. Utilization targets shall be identified in each network. If actual utilization is below such utilization targets, the entire amount within risk pools shall be returned to the primary care contractors on a quarterly basis. If actual utilization exceeds targets, the costs associated with such excess utilization shall be deducted by the Administration from the risk pools on a dollar-for-dollar basis. Any residual funds

remaining in a risk pool shall be distributed to the primary care contractor on a quarterly basis.

2. Ten percent of the capitation paid to specialty care providers may be withheld by the Administration and deposited into an inpatient risk pool fund. If the Administration determines to do so to prevent over utilization or other misuse of the system, hospital utilization shall be monitored on a monthly basis to compare actual utilization experience with targeted utilization. Hospital utilization targets shall be identified in each network. If actual utilization is below utilization targets, the entire amount in the inpatient risk pool shall be returned to the specialty care contractor following the close of the contract year. If actual utilization exceeds targets, costs associated with excess utilization shall be deducted by the Administration from the risk pool on a dollar-for-dollar basis. Any residual funds remaining in the risk pool shall be distributed to the specialty care contractor, on a quarterly basis.

Historical Note

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule is similar to the emergency (Supp. 83-3). Repealed effective October 1, 1983 (Supp. 83-5). Former Section R9-22-713 renumbered and amended as Section R9-22-714 effective October 1, 1985 (Supp. 85-5).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-715. Hospital Rate Negotiations

A. Effective for inpatient hospital admissions and outpatient hospital services on or after March 1, 1993, contractors that negotiate with hospitals for inpatient or outpatient services shall reimburse hospitals for member care based on the prospective tiered-per-diem amount, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges in A.R.S. § 36-2903.01 and R9-22-712, or the negotiated rate that, when considered in the aggregate with other hospital reimbursement levels, does not exceed what would have been paid under A.R.S. § 36-2903.01 and R9-22-712. This subsection does not apply to hospitals participating in the pilot program under R9-22-718.

1. Contractors may engage in rate negotiations with hospitals at any time during the contract period.
2. Within 7 days of the completion of the agreement process, contractors shall submit copies of their negotiated rate agreements, including all rates, terms, and conditions, with hospitals to the Administration for approval. Contractors shall demonstrate to the Administration that the effect of their negotiated rate agreement will, when considered in the aggregate, be the same as or produce greater dollar savings than would have been paid under A.R.S. § 36-2903.01 and R9-22-712.
   a. To demonstrate the aggregate effect of its negotiated rate agreement, contractors shall present their assumptions related to projected utilization of various hospitals to the Administration. The contractor may consider inpatient assumptions related to:
      i. Member mix;
      ii. Admissions by AHCCCS-specified tiers;
      iii. Average length of stay by tier and pattern of admissions, excluding emergency admissions;
      iv. Outliers; and
      v. Risk-sharing arrangements.
   b. The contractor also may consider outpatient assumptions related to member mix and outpatient service utilization. The Administration reserves the right to approve, deny, or require mutually-agreed-to modifications of these assumptions.
   c. When a contractor adjusts or modifies an assumption, the reason for the adjustment or modification shall be presented to the Administration, as well as the new assumption. The Administration may approve, deny, or require mutually-agreed-to modification of an assumption.
   d. To determine whether a negotiated rate agreement produces reimbursement levels that do not in the aggregate exceed what would be paid under A.R.S. § 36-2903.01 and R9-22-712, a contractor shall require its independent auditors to evaluate the reasonableness of its assumptions as part of its annual audit. The contractor shall ensure that its independent auditor's audit program is consistent with AHCCCS audit requirements and is submitted to the Administration for prior approval.
   e. Negotiated inpatient or outpatient rate agreements with hospitals with a contractor has a related-party interest are subject to additional related party disclosure and evaluation. These evaluations are in addition to the procedures described in subsection (A)(2)(c) and shall be performed by the contractor's independent auditors, or, at the contractor's option, by the Administration.
   f. The Administration shall subject a contractor's independent auditor's report to any examination or review necessary to ensure accuracy of all findings related to aggregate rate determinations.
   g. The Administration shall use its standards, consistent with the Request for Proposals and R9-22-502, to determine whether a contractor's inpatient or outpatient hospital subcontractors will limit the availability or accessibility of services. The Administration reserves the right to reject hospital subcontracts that limit the availability or accessibility of services.

B. The Administration may negotiate or contract with a hospital on behalf of a contractor for discounted hospital rates and may require that the negotiated discounted rates be included in a subcontract between the contractor and hospital.

C. The Director shall apportion any cost avoidance in the hospital component of provider capitation rates between the Administration and provider. The Administration's portion of the cost avoidance shall be reflected in reduced capitation rates paid to providers.

Historical Note

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to the emergency (Supp. 83-3). Repealed effective October 1, 1983 (Supp. 83-5). New Section R9-22-715 adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective

January 14, 1997 (Supp. 97-1). Amended effective September 22, 1997 (Supp. 97-3).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-716. Specialty Contracts

The Director may at any time negotiate or contract on behalf of providers, noncontracting providers, and the Administration for specialized hospital and medical services including, but not limited to, neonatology, neurology, cardiology, and burn care. If the Director contracts for specialized services, contractors of record may be required to include the services within their delivery networks and make contractual modifications necessary to carry out this Section. Specialty contractors shall take precedence over all other contractual arrangements between contractors of record and their subcontractors. Specialty contractors may require interim payments to specialty contractors on behalf of contractors of record for contract services received by members. Interim payments to specialty contractors may be deducted from capitation payments, performance bonds, or other monies for payment on behalf of contractors of record. If the Administration and a hospital that performed a transplant surgery on an eligible person do not have a contracted rate, the system shall not reimburse the hospital more than the contracted rate established by the Administration.

Historical Note

Adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective January 14, 1997 (Supp. 97-1).

R9-22-717. Hospital Claims Review

A. The Administration and its contractors shall review hospital claims that are timely received as specified in R9-22-703(B).

B. A charge for hospital services provided to an eligible person during a time when the eligible person was not the financial responsibility of the Administration shall be denied.

C. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
1. Patient care kit,
2. Toothbrush,
3. Toothpaste,
4. Petroleum jelly,
5. Deodorant,
6. Septi soap,
7. Razor,
8. Shaving cream,
9. Slippers,
10. Mouthwash,
11. Disposable razor,
12. Shampoo,
13. Powder,
14. Lotion,
15. Comb, and
16. Patient gown.

D. The following hospital supplies and equipment, if medically necessary and used, are covered services:
1. Arm board,
2. Diaper,
3. Underpad,
4. Special mattress and special bed,
5. Gloves,
6. Wrist restraint,
7. Limb holder,
8. Disposable item used in lieu of a durable item,
9. Universal precaution,
10. Stat charge, and
11. Portable charge.

E. The hospital claims review shall determine whether services rendered were:
1. AHCCCS-covered services;
2. Medically necessary;
3. Provided in the most appropriate, cost-effective, least restrictive setting; and
4. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2903.01(J) or 36-2904(K), whichever is applicable.

F. If a claim is denied by either the Administration or its contractor, a grievance challenging the denial may be filed against the entity denying the claim. The grievance shall be filed no later than 12 months from the date of service, 12 months from the date of eligibility posting, or 35 days from the date of notice of adverse action, whichever is latest. Any grievance challenging a postpayment review recoupment action shall be filed by the provider no later than 12 months from the date of service, 12 months from the date of eligibility posting, or 35 days from the date of the notice of recoupment, whichever is latest.

Historical Note

Adopted effective July 30, 1993 (Supp. 93-3). Amended effective September 22, 1997 (Supp. 97-3).

Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council. The agency was required to submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and was required to hold a public hearing.

R9-22-718. Inpatient Hospital Reimbursement Pilot Program

A. Definitions. In this Section, the following definitions apply:
1. "Contractor" means Maricopa and Pima organizations or entities as defined in Laws 1996, Ch. 288, § 20, which agree through a direct contracting relationship with the Administration to provide services as described by A.R.S. § 36-2901 or 36-2902. A contractor also includes the Department of Economic Security - Developmental Disabilities, who delivers medical and long-term care services to eligible Arizona Long-term Care members.
2. "Hospital contracts" means a contract between a contractor and hospital provider.
3. "RFP" means a request for proposal as prescribed by A.A.C. R9-28-101(54), R9-22-603, and R9-28-604.

B. General Provisions. The Administration shall operate a hospital reimbursement pilot program in which contractors in Maricopa and Pima counties shall enter into hospital contracts with 1 or more hospitals in geographical service areas within these counties. The geographic service area may vary from official county boundaries in certain zip codes bordering Maricopa and Pima counties. The Administration shall specify any variations in its RFP. These hospital contracts shall cover inpatient acute care hospital services for eligible persons with admissions on and after October 1, 1997, as follows:

1. Expiration date. The Hospital Reimbursement Pilot shall be effective until September 30, 2000.
2. Outpatient hospital services. As prescribed in A.A.C. R9-22-705 and R9-28-705, outpatient hospital services, including observation days and emergency room treatments that do not result in an admission, may be reimbursed either through a hospital contract negotiated between a contractor and a hospital, or the reimbursement rates set forth in A.R.S. § 36-2903.01(J). Outpatient hospital services that result in an admission shall be included in this pilot.
3. Out-of-area hospital services. Payment to hospitals outside of Maricopa and Pima counties are not included in the pilot.
4. Exclusions. A contractor shall not be:
   a. The Department of Health Services, Behavioral Health and Children Rehabilitative Services;
   b. Tribal governments;
   c. Department of Economic Security - Comprehensive Medical Dental Plan; and
   d. Health Care Group.

C. Hospital Contracts. The AHCCCS Director may approve or disapprove hospital contracts.
1. Provisions of hospital contracts. The provisions of the hospital contract must contain but are not limited to the following:
   a. Required provisions as described in A.A.C. R9-22-403 or R9-28-603;
   b. Dispute settlement procedures. If the grievance and appeal procedure prescribed in A.R.S. § 36-2903.01(B) and A.A.C. R9-22-801 through R9-22-805 and R9-28-801 through R9-28-804 is not used, then arbitration shall be used.
   c. Arbitration procedure. If arbitration is to be used, the contract shall identify:
      i. The parties' agreement on arbitrating claims arising from the contract,
      ii. Whether arbitration is nonbinding or binding,
      iii. Timeliness of arbitration,
      iv. What contract provisions may be appealed,
      v. What rules will govern arbitrations,
      vi. The number of arbitrators that will be used,
      vii. How arbitrators will be selected, and
      viii. How arbitrators will be compensated.
   d. Timeliness of claims submission and payment;
   e. Prior authorization;
   f. Concurrent review;
   g. Electronic submission of claims;
   h. Claims review criteria;
   i. Payment of discounts or penalties such as quick-pay and slow-pay provisions;
   j. Payment of outliers;
   k. Claim documentation specifications which meet the requirements of Laws 1996, Ch. 288, § 20;
   l. Treatment and payment of emergency room services; and
   m. Provisions for rate changes and adjustments.
2. AHCCCS review and approval of hospital contracts.
   a. The Administration may review, approve, or disapprove the hospital contract rates, terms, and conditions as well as any amendments to the contract.
   b. The contractor shall submit hospital contracts and amendments as specified in the RFPs for the contract year beginning October 1, 1997, or as specified in the RFP for new hospital contracts negotiated after October 1, 1997.
   c. The evaluation of each hospital contract shall include but not be limited to the following areas:
      i. Availability and accessibility of services to members,
      ii. Related party interests,
      iii. Inclusion of required terms pursuant to this Section, and
      iv. Reasonableness of the rates.
3. Evaluation of contractor's use of noncontracted hospitals. The Administration shall evaluate the contractor's use of contracted versus noncontracted hospitals pursuant to A.A.C. R9-22-603 or R9-28-604. The purpose of this evaluation is to encourage use of contracted facilities as opposed to noncontracted facilities.
4. Marketing materials. The Administration shall monitor the marketing of hospital networks in accordance with R9-22-504 and R9-22-505. A contractor must have an AHCCCS-approved contract with a hospital to include the hospital in that contractor's marketing materials.

D. Transplants. In no case may a contractor's rate exceed the rate established by the Administration for an acute care inpatient stay in which a covered transplant was performed that qualified for catastrophic reinsurance. The contractor may either reimburse the hospitals through the terms of the hospital contract or, in the absence of a hospital contract, at the specialty hospital contract rate established by the Administration pursuant to R9-22-712(A)(4).

E. Noncontracted hospital provider. In the absence of a hospital contract between a Maricopa or Pima county contractor and hospital, the contractor shall pay the hospital for inpatient services based on the tiered per diem rates for that hospital as defined in A.R.S. § 36-2903.01 and A.A.C. R9-22-712, as of September 30, 1997, multiplied by 95%, unless otherwise negotiated by both parties. If at any time graduate medical education is reimbursed by the Administration outside of the tier rates, the Administration shall adjust the tier rates in effect as of September 30, 1997, accordingly. The contractors shall meet the requirements prescribed in A.A.C. R9-22-705 and R9-28-705.
1. No annual adjustments. The Administration shall make no annual adjustments to these tiered per diem rates for:
   a. Inflation,
   b. Capital costs,
   c. Changes in length of stay, and
   d. Changes made in the rates as a result of rebasing the tiered per diems system pursuant to A.R.S. § 36-2903.01(J).
2. Outlier policy. When there is no pilot negotiated hospital contract, reimbursement of outliers is based upon updated outlier thresholds, and 95% of the statewide average cost-to-charge ratio in effect on September 30, 1997.
3. Quick-pay/slow-pay policy. Payments made to noncontracted hospitals shall be subject to quick-pay discounts and slow-pay penalties in accordance with Laws 1993, Ch. 6, § 29; Laws 1992, Ch. 302, § 14, as amended by Laws 1993, Ch. 6, § 27; and A.R.S. § 36-2904.
4. New hospitals or hospital tiers. For any new hospitals or hospital tiers that are established after September 30, 1997, the tiered per diem rate that would have been established for new hospitals on September 30, 1997, as prescribed in R9-22-712, will be paid at 95%.

F. Reinsurance. For contractors in Maricopa and Pima counties, reinsurance thresholds shall be calculated pursuant to A.A.C. R9-22-503 or R9-28-709.

Historical Note

Adopted under an exemption from the provisions of the

Administrative Procedure Act, effective January 29, 1997; pursuant to Laws 1996, Ch. 288, § 24 (Supp. 97-1).

ARTICLE 8. GRIEVANCE AND APPEAL PROCESS

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-801. General Provisions For All Grievances and Appeals

A. Definitions. In this Article:
1. "Appellant" means an individual filing any grievance or appeal under this Article.
2. "Request for hearing" means an appeal of an adverse eligibility action; an appeal filed after an informal decision has been rendered on a grievance by the Administration; an appeal of a grievance decision rendered by a contractor; or an appeal filed because a contractor has failed to render a timely grievance decision.
3. "Respondent" means the party responsible for the action being grieved or appealed. In eligibility appeals regarding state-funded services, the county is the respondent. In eligibility appeals regarding SSI-related medical assistance only services, the Administration is the respondent. In most member grievances, the contractor generally is the respondent.

B. Filing grievances and appeals. Unless provided elsewhere in this Chapter, all grievances and appeals or other statements shall be considered filed when received in writing by the Administration.

C. Computation of time. In computing any period of time for establishing timeliness of filing grievances and appeals, the period shall commence the day after the act, event, or decision grieved or appealed, and shall include all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period shall be extended until the end of the next day that is not a weekend or a legal holiday.

D. Appellant's hearing rights. The Administration shall afford an appellant the right to:
1. Have a hearing that is conducted as specified in A.R.S. §§ 41-1061 and 41-1062.
2. Obtain copies of any relevant document from the respondent or from AHCCCS at the appellant's expense.
3. Appear at the hearing and be heard in person, by telephone if available, through a representative designated in writing by the appellant, or to submit to the Administration a written statement that is signed and notarized prior to the hearing.
4. Bring an interpreter to assist at the hearing.
5. Be provided an interpreter by the Administration if hearing-challenged according to A.R.S. § 12-242.

E. Withdrawal or denial of a request for hearing.
1. The AHCCCS Chief Hearing Officer or designee shall deny a request for hearing and deny a grievance or appeal if a written request for withdrawal is received from the appellant before the date of the hearing. The case file then shall be closed.
2. The AHCCCS Chief Hearing Officer or designee may deny a request for hearing and dismiss a grievance or appeal upon written determination that:
   a. The request for hearing is untimely;
   b. The request for hearing, grievance, or appeal is not for a reason permitted under this Article;
   c. The appellant's appeal rights have been waived under Article 3; or
   d. The appeal is otherwise moot.

F. Notice of Hearing. The Notice of Hearing shall be in accordance with A.R.S. § 41-1061 and shall include the following information:
1. A statement asserting the appellant's financial liability if AHCCCS benefits are continued during an eligibility appeal and a proposed discontinuance or redetermination denial is upheld by the Director, and
2. A statement informing an appellant how to request a change in the scheduled hearing date.

G. Postponement.
1. The AHCCCS Chief Hearing Officer or designee on the officer or designee's own motion may postpone a hearing. When a request for postponement is made, it shall be in writing and received by the Administration, Office of Grievance and Appeals, no later than 5 days before the scheduled hearing date. The AHCCCS Chief Hearing Officer or designee may grant a request for postponement on a showing that:
   a. There is substantial cause for the postponement, and
   b. The cause is beyond the reasonable control of the party making the request.
2. If a postponement is granted, the hearing shall be rescheduled at the earliest practicable date.

H. Failure to appear for hearing. If any party or representative fails to appear at a hearing without good cause or a postponement, the AHCCCS Chief Hearing Officer or designee may:
1. Proceed with the hearing,
2. Reschedule the hearing with further notice,
3. Issue a decision based on the evidence of record, or
4. Issue a default disposition.

I. Conduct of hearing. The hearing shall be conducted as specified in to A.R.S. §§ 41-1061 and 41-1062.
1. The hearing shall be conducted in an informal manner without formal rules of evidence or procedure.
2. The AHCCCS Chief Hearing Officer or designee may:
   a. Hold pre-hearing conferences to settle, simplify, or identify issues in a proceeding, or to consider other matters that may aid in the expeditious disposition of the proceeding;
   b. Require parties to state their positions concerning the various issues in the proceeding;
   c. Require parties to produce for examination those relevant witnesses and documents under their control;
   d. Rule on motions and other procedural items;
   e. Regulate the course of the hearing and conduct of participants;
   f. Establish time limits for submission of motions or memoranda;
   g. Impose appropriate sanctions against any individual failing to obey an order under these procedures, which may include:
      i. Refusing to allow the individual to assert or oppose designated claims or defenses, or prohibiting that individual from introducing designated matters in evidence;
      ii. Excluding all testimony of an unresponsive or evasive witness; and/or
      iii. Expelling the individual from further participation in the hearing;

h. Take official notice of any material fact not appearing in evidence in the record, if the fact is among the traditional matters of judicial notice; and
i. Administer oaths or affirmations.

J. AHCCCS Hearing Officer recommended decision. After the conclusion of the hearing, unless the appellant withdraws or the parties stipulate to a settlement, the AHCCCS Hearing Officer shall prepare written findings of fact and conclusions of law and render a recommended decision to the Director.

K. Decision of the Director.
1. The Director may affirm, modify, or reject the Hearing Officer's recommendation in whole or in part; may remand a matter to any party or the Hearing Officer with specific instructions; or make any other appropriate disposition.
2. The Director shall mail by certified mail a copy of the decision to all parties at the last known residence or place of business of each party.
3. If a discontinuance or denial of AHCCCS eligibility is upheld, the decision also shall state that the appellant may reapply for AHCCCS benefits under the conditions specified in Article 3.

L. Petition for rehearing or review.
1. A party dissatisfied with the decision may petition the Director for rehearing or review of the decision for any of the following causes which materially affects the appellant's rights:
   a. Irregularity in the proceedings of the hearing or appeal whereby the aggrieved party was deprived of a fair hearing or appeal;
   b. Misconduct of a party or the agency;
   c. Newly discovered material evidence, which with reasonable diligence could not have been discovered and produced at the hearing;
   d. That the decision is the result of passion or prejudice; or
   e. That the decision is not justified by the evidence or is contrary to law.
2. The petition for rehearing or review shall be filed not later than 15 days after the date of the Director's decision, which is the postmark date of the decision. The moving party also shall send a copy of the petition to all other parties. If a timely petition for rehearing or review is filed, the Director's decision is not a final administrative decision; rather, the final administrative decision is the decision the Director renders as a result of the petition.
3. The petition for rehearing or review shall be in writing and shall specifically state the grounds upon which it is based. The Director shall review the sufficiency of the evidence if the petition is made upon the ground that the decision is not justified by the evidence.
4. The Director may remand the case to any party; reopen the decision; order the taking of additional testimony or evidence before the Hearing Officer; amend findings of fact and conclusions of law; make new findings and conclusions; render an amended decision; or deny the petition and affirm the previous decision.
5. The Director, within the time for filing a petition for rehearing or review, may on the Director's own motion order a rehearing or issue an amended decision for any reason for which the Director might have done so upon petition of a party.

M. Failure to submit a grievance, appeal, request for hearing, or petition for rehearing or review in a timely manner shall constitute a failure to exhaust administrative remedies required as a condition to seeking judicial relief.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-801 adopted as an emergency adoption now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-801 repealed, new Section R9-22-801 adopted effective October 29, 1985 (Supp. 85-5). Amended subsections (C), (F), (H), (I), and (K) effective October 1, 1986 (Supp. 86-5). Change of heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (H) effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Section heading amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-801 repealed, new Section R9-22-801 adopted January 14, 1997 (Supp. 97-1).

R9-22-802. Eligibility Appeals For Applicants, Eligible Persons and Members Receiving State-funded AHCCCS Services

A. Adverse eligibility actions. An applicant, eligible person, or member receiving state-funded AHCCCS services may appeal and request a hearing concerning any of the following adverse eligibility actions:
1. Denial of eligibility,
2. Discontinuance of eligibility, or
3. Delay in the eligibility determination beyond 30 days from the date of application unless the head of household agrees to an extension in writing.

B. Notice of an adverse eligibility action shall be personally delivered or mailed to the affected individual by regular mail. For purposes of this Section, the date of the Notice of Action shall be the date of personal delivery to the individual or the postmark date, if mailed.

C. Appeals and requests for hearing.
1. An applicant, eligible person, member, head of household, or designated representative may appeal and request a hearing regarding an adverse eligibility action by completing and submitting the AHCCCS Request for Hearing form or by submitting a written request containing the following information:
   a. The case name,
   b. The adverse eligibility action being appealed, and
   c. The reason for appeal.
2. A request for hearing shall be filed not later than 15 days after the date of the notice of adverse action by mailing or delivering it to either the county eligibility office or the Administration, Office of Grievance and Appeals. For this Section only, the date of the request for hearing shall be the postmark date, if mailed, or the date of personal delivery.

D. County responsibilities.
1. Counties shall maintain a register that documents the dates on which requests for hearings are submitted.
2. If requested, a county eligibility office shall assist an appellant or designated representative to complete of a Request for Hearing form.
3. A Pre-hearing Summary shall be completed by the county eligibility office and shall summarize the facts and factual basis for the adverse eligibility action.
4. The county eligibility office shall send to the Administration, Office of Grievance and Appeals, the Pre-hearing Summary, a copy of the case file, and the Request for

Hearing, which must be received by the Administration, Office of Grievance and Appeals, not later than 10 days from the date the county received the request for hearing. If the request for hearing is submitted directly to the Administration, the county shall send the materials to the Office of Grievance and Appeals not later than 10 days from the date of a request for the materials.

5. County review of eligibility determinations. If new information is acquired by the county that materially affects the adverse eligibility decision, the county shall complete a new application and render a decision according to the requirements specified in Article 3. The effective date of AHCCCS coverage shall be the date established in Article 3. A county decision in accordance with this subsection shall not be considered a disposition of a pending appeal.

E. AHCCCS coverage during the appeal process.

1. Eligible persons or members appealing a discontinuance. A discontinuance is a termination of AHCCCS benefits before the last month of an individual's certification period. The effective date of a discontinuance shall be the 16th day after the date of the Notice of Action. An eligible person or member appealing a discontinuance of AHCCCS benefits within the 15-day time-frame as specified in subsection (C) shall continue to be covered by AHCCCS until an adverse decision on appeal is rendered or until the end of the certification period set forth in R9-22-313, whichever comes 1st.
2. Individuals appealing a denial of AHCCCS coverage.
   a. A denial is an adverse eligibility decision that finds an applicant, eligible person, or member ineligible for AHCCCS benefits. A denial results from either an initial application or a redetermination that does not terminate benefits before the end of a current certification period.
   b. The effective date of a denial of an initial application is the date of the Notice of Action. An individual may appeal this denial within the 15-day time-frame specified in subsection (C). If the denial is overturned, the effective date of AHCCCS coverage shall be established by the Director in accordance with applicable law.
   c. The effective date of a denial of a redetermination shall be the last day of the final month in the current certification period. An individual who appeals this denial within the 15-day time-frame specified in subsection (C) shall continue to be covered by AHCCCS until administrative remedies are exhausted.

3. An individual whose benefits are continued shall be financially liable for all AHCCCS benefits received during a period of ineligibility if a discontinuance decision or redetermination denial is upheld by the Director.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-802 adopted as an emergency adoption now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 29, 1985 (Supp. 85-5). Amended subsections (A), (B), (C) and (D) effective October 14, 1988 (Supp. 88-4). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-802 repealed, new Section R9-22-802 adopted effective January 14, 1997 (Supp. 97-1).

R9-22-803. Eligibility Appeals for Applicants, Eligible Persons, and Members Receiving SSI-Related Medical Assistance Only AHCCCS Services

A. Adverse eligibility actions. An applicant, eligible person, or member receiving SSI-related medical assistance only AHCCCS services may appeal and request a hearing concerning any of the following adverse eligibility actions:

1. Denial of eligibility,
2. Discontinuance of eligibility, or
3. Delay in the eligibility determination beyond the 45- or 90-day time-frame prescribed in federal law from the date of application unless the applicant or representative agrees to an extension in writing.

B. Notice of an adverse eligibility action shall be personally delivered or mailed to the affected individual by regular mail. For purposes of this Section, the date of the Notice of Action shall be the date of personal delivery to the individual or the postmark date, if mailed.

C. Appeals and requests for hearing.

1. An applicant, eligible person, member, or designated representative may appeal and request a hearing regarding an adverse eligibility action by completing and submitting the AHCCCS Request for Hearing form or by submitting a written request containing the following information:
   a. The case name,
   b. The adverse eligibility action being appealed, and
   c. The reason for appeal.
2. For denials, the request for hearing shall be filed not later than 20 days from the date of the notice of adverse action. For discontinuances, the request for hearing shall be filed not later than 10 days after the effective date of action. The request for hearing shall be filed by mailing or delivering it to either the AHCCCS eligibility office or the Administration, Office of Grievance and Appeals. For this Section only, the date of the request for hearing shall be the postmark date, if mailed, or the date of personal delivery.

D. Eligibility office responsibilities.

1. The eligibility office shall maintain a register that documents the dates on which requests for hearings are submitted.
2. If requested, the eligibility office shall assist an appellant or designated representative to complete a Request for Hearing form.
3. A Pre-hearing Summary shall summarize the facts and factual basis for the adverse eligibility action.
4. The eligibility office shall send to the Administration, Office of Grievance and Appeals, the Pre-hearing Summary, a copy of the case file, and the Request for Hearing, which must be received by the Administration, Office of Grievance and Appeals, not later than 10 days from the date the eligibility office received the request for hearing. If the request for hearing is submitted directly to the Administration, Office of Grievance and Appeals, the eligibility office shall send the materials to the office of Grievance and Appeals not later than 10 days from the date of a request for the materials.

E. AHCCCS coverage during the appeal process.

1. Eligible persons or members appealing a discontinuance. A discontinuance is a termination of AHCCCS benefits. For actions requiring 10 days' advance notice, an eligible person or member requesting a hearing before the effective date of the adverse action shall continue to receive AHCCCS benefits until an adverse decision on the appeal is rendered.
2. Applicants appealing a denial of AHCCCS coverage.

a. A denial is an adverse eligibility decision that finds an applicant ineligible for AHCCCS benefits.
b. An applicant may appeal a denial within the timeframes specified in subsection (C)(2). If the denial is overturned, the effective date of AHCCCS coverage shall be established by the Director in accordance with applicable law.

3. An eligible person or member whose benefits are continued shall be financially liable for all AHCCCS benefits received during a period of ineligibility if a discontinuance decision is upheld by the Director.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-803 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-803 repealed, new Section R9-22-803 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-803 renumbered and amended as Section R9-22-804. Adopted effective January 31, 1986 (Supp. 86-1). Amended effective September 29, 1992 (Supp. 92-3). Former Section R9-22-803 repealed, new Section R9-22-803 adopted January 14, 1997 (Supp. 97-1).

R9-22-804. Grievances

A. This Section provides the exclusive manner through which any individual or entity may grieve against the Administration, its contractors, or both in connection with any adverse action, decision, or policy. This Section shall not apply to actions or decisions affecting an eligible person's or member's eligibility or to actions or decisions that reduce a categorically eligible person's or member's benefits as a result of changes in state or federal law.

B. Direct grievances to the Administration.

1. A grievance may be filed directly with the agency only by individuals not enrolled with a contractor; by contractors; by counties; and by individuals or entities grieving an adverse action, decision, or policy actually made or enacted by the Administration. If the aggrieved adverse action, decision, or policy actually was made by a contractor, the appellant shall first file the grievance with the contractor responsible for the decision, policy, or action being grieved, so the contractor may investigate and resolve the grievance in accordance with this Article and any applicable contracts.
2. Except as provided in subsection (B)(3) a written grievance shall be filed with and received by the Administration not later than 35 days after the date of the adverse action, decision, or policy implementation being grieved.
3. A written grievance regarding a claim denial shall be filed not more than 12 months after the date of the service for which payment is claimed. A grievance challenging a reinsurance claim denial by the Administration shall be filed not more than 12 months after the close of the contract year in which the claim was incurred. If the claim is denied less than 35 days before expiration of the 12-month time period, the dissatisfied party shall have 35 days from the date of the denial to file the grievance.
4. A grievance shall state with particularity the factual and legal basis for the grievance and the relief requested. Failure to comply with this specificity requirement shall result in the denial of the grievance.
5. The Administration, in its sole discretion, may investigate a grievance and render a written informal decision before scheduling a hearing. A hearing shall be scheduled if any party timely requests a hearing within 15 days of the postmark date of the informal decision.
6. If a hearing is requested, it shall be conducted as provided in R9-22-801.

C. Grievances to contractors.

1. Except as provided in subsection (C)(2) a grievance shall be filed with and received by the appropriate contractor not later than 35 days after the date of the adverse action or decision. Members may file grievances orally.
2. A written grievance regarding a claim denial shall be filed not more than 12 months after the date of the service for which payment is claimed.
3. A grievance shall state with particularity the factual and legal basis for the grievance and the relief requested. Failure to comply with this specificity requirement shall result in the denial of the grievance.
4. A final decision shall be rendered by the contractor on all grievances within 30 days of filing unless the parties agree on a longer period. The decision by the contractor shall be personally delivered or mailed by certified mail to the parties, and shall state the basis for the decision as well as the grievant's right to appeal the decision to the Administration. The contractor's final decision shall specify the manner in which an appeal to the Administration may be filed.
5. The contractor shall record and retain information to identify the grievant, date of receipt, and nature of the grievance.
6. At the time of enrollment, a contractor shall give to a member written information regarding grievance procedures available through the contractor and the Administration.

D. Appeal of contractor decisions to the Administration.

1. After first grieving to the appropriate contractor, a grievant may appeal to and request a hearing from the Administration, Office of Grievance and Appeals if:
   a. The grievant files a written notice of appeal not more than 15 days from the date of final decision of the contractor, which is the earlier of the date of personal delivery or the postmark date of certified mail; or
   b. A decision is not timely rendered by the contractor until 30 days, and the grievant files a written notice of appeal based upon the contractor's failure or refusal to decide the grievance in a timely manner.
2. The Administration, in its sole discretion, may investigate a grievance and render a written informal decision before scheduling a hearing. A hearing shall be scheduled if any party timely requests a hearing within 15 days from the postmark date of the informal decision of the Administration.
3. If a hearing is requested, it shall be conducted as provided in R9-22-801.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-804 adopted as an emergency adoption now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Former Section R9-22-804 repealed, former Section R9-22-803 renumbered and amended as Section R9-22-804 effective October 29, 1985 (Supp. 85-5). Amended effective October 14, 1988 (Supp.88-4). Amended subsections (B) and (C) effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December

13, 1993 (Supp. 93-4). Former Section R9-22-804 repealed, new Section R9-22-804 adopted effective January 14, 1997 (Supp. 97-1).

R9-22-805. Repealed

Historical Note
Former Section R9-22-805 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective January 31, 1986 (Supp. 86-1).

ARTICLE 9. QUALITY CONTROL REVIEW AND ANALYSIS

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule.

R9-22-901. Definitions
The terms used in this Article have the following meanings:

1. "Certification errors" has the meaning defined in A.R.S. § 36-2905.01(I) and R9-22-902.
2. "Corrective action plan" means a plan developed by a county to reduce its error rate calculated pursuant to A.R.S. § 36-2905.01(A).
3. "Fraudulent information" means incorrect information intentionally provided with the purpose of obtaining benefits to which the applicant would not otherwise be entitled.
4. "Good cause" means events that are beyond the control of the county or its agents which cause inability to comply with the requirements of submitting case files to the Administration.
5. "Improperly classified" means a person who was certified as indigent or medically needy but was eligible only under the criteria for eligible low-income children, or a person who was erroneously certified as indigent or medically needy and who is approved for categorical eligibility or a person who was certified as indigent or medically needy or as an eligible low-income child but was eligible only under the criteria for state emergency services.
6. "Improperly incurred expenses" means all expenses paid by the Administration or paid or incurred by providers or nonproviders on behalf of an ineligible person, a person certified through a certification error, the difference between the amount of capitation paid and the correct amount for a person improperly classified, or expenses resulting from the county's failure to take timely action to discontinue or adjust benefits. "Improperly incurred expenses" also means two-thirds of all expenses paid or incurred by providers or nonproviders on behalf of a hospitalized person potentially eligible for Title XIX, who was not referred for federal emergency services and who would have been approved for Title XIX had the person been referred.
7. "Loss of contact" means that a member could not be located at the address of record and there is no alternate or forwarding address known to the Administration or the county.
8. "Quality control analysis" means the AHCCCS analysis of a county's eligibility files pursuant to A.R.S. § 36-2905.02.
9. "Quality control review" means the AHCCCS review of a county's eligibility files pursuant to A.R.S. § 36-2905.01.
10. "Review Committee" means the persons designated by the Director to review and make decisions on county challenges of certification errors.
11. "Review period" means the period during which member files are selected for review of eligibility.
12. "Timely action" means the county took appropriate action to adjust or discontinue benefits in accordance with the time frames prescribed by Article 3.
13. "Total capitation payment" means the amount of capitation paid by AHCCCS to providers in a county for the review period. This includes any retroactive adjustments in capitation rates.

Historical Note
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-901 adopted as an emergency adoption now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective August 29, 1985 (Supp. 85-4). Amended effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule.

R9-22-902. Certification Errors

A. Certification errors for quality control reviews and quality control analyses include:
1. Certification of an applicant who was in fact ineligible because:
   a. Income exceeded the income limit;
   b. Total resources exceeded the liquid or total resource limits;
   c. Transfer of property;
   d. The applicant was not an Arizona resident;
   e. The applicant did not meet the family household criteria;
   f. Someone was improperly included or excluded from the AHCCCS family household; or
   g. The applicant was not a citizen of the United States or an alien who meets the requirements of 42 CFR 435.406(a), March 14, 1991, incorporated by reference herein and on file with the Office of the Secretary of State.
2. The case file was not available for review and the written explanation provided by the county did not establish good cause for the absence of the case file pursuant to A.R.S. §§ 36-2905.01(D) or 36-2905.02(F).
3. Certification of an applicant when any eligibility requirement was not met including:
   a. Approving a potentially eligible S.O.B.R.A. person or an emergency services applicant potentially eligible for Title XIX, or failing to discontinue a hospi-

talized person potentially eligible for Title XIX, who has refused to cooperate in the federal eligibility determination process, pursuant to A.R.S. § 11-297, 36-2905, 36-2905.03, or 36-2905.05.

b. Approving a potentially eligible Title XIX person when Title XIX eligibility has not been determined, except:
   i. When the applicant is admitted to a hospital as an inpatient at any time while the application is pending, or
   ii. After a S.O.B.R.A. application has been completed and submitted to DES by the county by 31 days from the date of application, but DES has not made a S.O.B.R.A. eligibility determination within ten working days from the date the completed S.O.B.R.A. application was received by DES.

c. Approving a hospitalized person who is a citizen of the United States or an alien who meets the requirements of 42 CFR 435.406(a), March 14, 1991, incorporated by reference herein and on file with the Office of the Secretary of State, except as permitted by R9-22-313(D) and R9-22-309.

d. Approving a state emergency services applicant except as permitted by R9-22-309 and R9-22-343(H) and (L).

B. An applicant under subparagraph (A)(3)(b) is ineligible for indigent, medically needy, eligible low-income child, or state emergency services coverage and the county shall be subject to sanctions until one of the following occurs:
1. Ten working days have elapsed since a completed S.O.B.R.A. application was received by DES from the county, but the S.O.B.R.A. eligibility decision is still pending; or
2. The person is approved for Title XIX by DES and the adjustment in capitation rate, if appropriate, has been made; or
3. The person is denied for Title XIX other than for a refusal to cooperate.

C. Certification errors for quality control analyses also include:
1. Improper classification of a person as indigent or medically needy when in fact the person met only the criteria for eligible low-income children.
2. The county failed to take timely action to discontinue benefits, in accordance with R9-22-316, R9-22-318, or R9-22-330, after receiving notice, from any source, containing cause for ineligibility.
3. Improper classification of a person as indigent or medically needy or as an eligible low-income child when in fact the person only met the criteria for state emergency services.

Historical Note

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-902 renumbered and amended as Section R9-22-904, former Section R9-22-903 renumbered and amended as Section R9-22-902 effective October 1, 1986 (Supp. 86-5). Former Section R9-22-902 repealed, new Section R9-22-902 adopted effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4).

R9-22-903. County responsibilities

In addition to other responsibilities required by this Article, a county shall observe the following:
1. Failure by a member to cooperate with a quality control review or a quality control analysis shall result in a member's discontinuance from AHCCCS. The county shall send an advance notice of discontinuance to the head of household within two days from the date of notification from the Administration of the member's failure to cooperate. Discontinuance shall be withdrawn if the county receives notice from the Administration during the advance notice period that the member is cooperating with the Administration.
2. A county shall initiate discontinuance of a household and send advance notice of discontinuance to the head of household within two days of receipt of notice from the Administration that loss of contact with a head of household has occurred in the course of a quality control review or a quality control analysis.
3. When a county claims that a certification error was based on fraudulent information, the county shall establish the existence of fraudulent information by clear and convincing evidence.
4. A notification to a county of a change in circumstances or any information which would effect eligibility shall result in a re-evaluation or redetermination in accordance with R9-22-330.
5. In all cases except those involving fraudulent information, the county shall establish by a preponderance of the evidence that the applicant is eligible for AHCCCS coverage.

Historical Note

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-903 renumbered and amended as Section R9-22-902, former Section R9-22-904 renumbered and amended as Section R9-22-903 effective October 1, 1986 (Supp. 86-5). Former Section R9-22-903 repealed, new Section R9-22-903 adopted effective May 30, 1989 (Supp. 89-2).

R9-22-904. Quality control review challenge process

A county may challenge review findings of certification errors in any case.
1. A challenge shall include evidence to support the county's claim of error by the Administration reviewer.
2. Failure to submit a challenge to the Administration within 30 days of the postmarked date of the initial report shall be deemed an acceptance by the county of the review findings and the finding of the AHCCCS Administration shall be final.
3. Challenges shall be reviewed by an AHCCCS Review Committee which may uphold, modify or overturn the review findings. If the review findings are overturned, the corrected status of the case shall be used in calculating the error rate pursuant to A.R.S. § 36-2905.01(A).
4. The Review Committee shall consider only documentary or written evidence presented by the quality control reviewer and the evidence submitted by the county. A county may submit evidence obtained subsequent to the date of AHCCCS notification of eligibility for consideration in the challenge process. The Review Committee shall base its decision on the most convincing evidence presented that establishes whether the member was in fact eligible for AHCCCS benefits as a medically indigent or medically needy person or eligible low-income child.

Historical Note
Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-904 renumbered and amended as Section R9-22-903, former Section R9-22-902 renumbered and amended as Section R9-22-904 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2).

R9-22-905. Quality control analysis challenge process
A county may challenge an error decision resulting from a quality control analysis.

1. Failure to submit a challenge to the Administration within 30 days shall be deemed an acceptance by the county of the analysis review findings and the findings of the AHCCCS Administration shall be final.
2. A county may submit documentary or written evidence obtained subsequent to the date of AHCCCS notification of eligibility for consideration in the challenge process.
3. All challenge evidence shall be reviewed by an AHCCCS Review Committee, which may uphold, modify or overturn the review findings. If the review findings are overturned, the county shall be absolved of all penalties that otherwise would have resulted from the review.
4. The Review Committee shall consider the documentary or written evidence presented by the quality control reviewer and the documentary or written evidence submitted by the county and shall base its decision on the most convincing evidence presented. The challenge shall be successful if a preponderance of the evidence establishes that a member was in fact eligible for AHCCCS benefits or if clear and convincing evidence establishes that a certification decision was based on fraudulent information.

Historical Note
Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-905 renumbered without change as Section R9-22-908, former Section R9-22-907 renumbered and amended as Section R9-22-905 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2).

R9-22-906. Corrective Action Plans for Certification Errors

A. A county with a certification error rate of more than 3%, as calculated according to A.R.S. § 36-2905.01(A), shall prepare a corrective action plan to reduce the certification error rate.

B. A county shall include in its corrective action plan procedures to reduce the occurrence of all certification errors that prevent the county from achieving an allowable eligibility certification error rate of 3% or less.

C. A county shall describe in its corrective action plan procedures that will be used by the county to:

1. Identify certification errors,
2. Analyze the frequency of occurrence of the certification errors,
3. Analyze the cause of the certification errors,
4. Develop and implement corrective actions for the certification errors, and
5. Identify the procedures for evaluating the effectiveness of the corrective action plan.

D. For each corrective action developed, a county shall prepare a narrative summary that contains the following information:

1. A statement identifying the certification error addressed by the corrective action;
2. An estimate of the certification error percentage caused by the identified error;
3. A summary explaining how the certification error was discovered (internal, Quality Analysis, Quality Control, etc.);
4. A description of the county system that existed when the certification error occurred;
5. A description of the subsequent or proposed changes to correct the certification error;
6. A summary of the expected certification error rate reduction resulting from the implementation of this corrective action; and
7. An estimate of when the certification error rate reduction is expected to be achieved.

E. For each corrective action developed and described in a county's corrective action plan, the county shall include a work plan that identifies:

1. The major activities or action steps planned to implement the initiative;
2. The individual responsible for each activity or action step;
3. The proposed timetable for implementing each activity or action step listed in the work plan (start date, planned completion date, etc.);
4. Who will monitor implementation of each work plan; and
5. How the effectiveness of the work plan will be evaluated.

F. A county shall submit an annual corrective action plan to the Administration within 60 days of issuance of the Administration's certification error rate report.

Historical Note
Adopted effective August 29, 1985 (Supp. 85-4).
Amended effective October 1, 1986 (Supp. 86-5).
Amended effective October 1, 1987 (Supp. 87-4).
Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3).

R9-22-907. Recovery of cost for covered services

A. Quality control analysis. Pursuant to A.R.S. § 36-2905.02, counties shall reimburse AHCCCS for any expenses improperly incurred by AHCCCS due to erroneous eligibility certifications. The following reimbursement conditions apply:

1. A county shall reimburse the Administration for any capitation paid to a contractor,
2. A county shall reimburse the Administration for any claims paid by the Administration,
3. A county shall reimburse the Administration for any reinsurance paid by the Administration, and
4. A county shall reimburse a provider or nonprovider which has incurred or paid expenses not already paid by the Administration, including expenses in excess of the capitations.

B. A county may file a grievance concerning the amount of a financial penalty resulting from a quality control review or analysis, pursuant to A.R.S. §§ 36-2905.01 or 36-2905.02, by following the county grievance process in accordance with Article 8. In the event that a county files a grievance concerning the amount of a financial penalty and the Director renders a final decision in favor of the county after the county has paid the financial penalty or the state treasurer has deposited any portion of the financial penalty into the Arizona Health Care Cost Containment System Fund pursuant to A.R.S. § 36-2905.02(C), the Administration shall refund to the county the amount specified by the Director in his decision.

Historical Note
Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-907 renumbered and amended as Section R9-22-905, former Section R9-22-908 renumbered and amended as Section R9-22-907 effective October 1, 1986

(Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2).

R9-22-908. Repealed

Historical Note

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-908 renumbered and amended as Section R9-22-907, former Section R9-22-905 renumbered without change as Section R9-22-908 effective October 1, 1986 (Supp. 86-5). Former R9-22-908 repealed effective May 30, 1989 (Supp. 89-2).

ARTICLE 10. 1ST-AND 3RD-PARTY LIABILITY AND RECOVERIES

R9-22-1001. 1st-and 3rd-Party Liability and Coordination of Benefits

A. Definitions. In this Section, the following definitions apply:
1. "1st-party liability" means the resources available from any insurance or other coverage obtained directly or indirectly by a member or eligible person that provides benefits directly to the member or eligible person and is liable to pay all or part of the expenses for medical services incurred by the Administration, a member, or eligible person.
2. "Cost avoidance" means avoiding payment of claims when 1st- or 3rd-party payment sources are available.

B. General provisions. The System shall be the payor of last resort, unless specifically prohibited by applicable state or federal law. The Administration may subcontract distinct administrative functions as permitted by A.R.S. §§ 36-2903(D) and 36-2915(B).

C. Cost avoidance. The System shall cost avoid all claims or services that are subject to 1st- or 3rd-party liability source, and may deny a service to a member or eligible person if it knows that a 1st or 3rd party will provide the service. The requirement to cost avoid applies to all AHCCCS-covered services, unless otherwise specified in this Section.
1. Responsible parties. The following parties shall take reasonable measures to identify legally liable 1st- or 3rd-party sources:
   a. Administration,
   b. Contractor,
   c. Provider,
   d. Nonprovider,
   e. Noncontracting provider,
   f. Member, and
   g. Eligible person.
2. Coordination of benefits. If a contractor does not know whether a particular service is covered by a 1st-and 3rd-party insurer, and the service is medically necessary, the contractor shall contact the 1st and 3rd party, and determine whether the service is covered rather than requiring the member or eligible person to contact the 1st or 3rd party. If the contractor knows that the 1st-and 3rd-party insurer will neither pay for nor provide the covered service, and the service is medically necessary, the contractor shall neither deny the service nor require a written denial letter.
3. Copayment, coinsurance, deductible. If a 1st- or 3rd-party insurer (other than Medicare) requires a member or eligible person to pay any copayment, coinsurance, or deductible, the contractor must decide whether it is more cost effective to provide the service:
   a. Within its network for continuity of care; or
   b. Outside its network for continuity of care under the following conditions:
      i. Advance payments. If an insurer requires payment in advance of a copayment, coinsurance, or deductible, the contractor shall make the payment in advance for the member or eligible person.
      ii. Limitation of copayment, coinsurance, and deductible amounts. A contractor that meets the requirements in subsection (C)(5) is not responsible for paying a copayment, coinsurance, or deductible that is in excess of what the contractor would have paid for the entire service, per a written contract with the provider performing the service, or the AHCCCS fee-for-service rate minus any amount paid by the 1st and 3rd party.
4. Exceptions. A contractor shall provide the following services, and then coordinate payment with a 1st- and 3rd-party payor:
   a. Emergency service;
   b. Medically necessary transportation service. If a contractor approves a covered service out of the contractor's network, the contractor shall provide all medically necessary transportation, so 1st- and 3rd-party benefits can be received.
5. Medically necessary service. A contractor shall ensure that its cost avoidance efforts do not prevent an eligible person or member from receiving a medically necessary service, and that the eligible person or member is not required to pay any copayment, coinsurance, or deductible for use of the other insurer's provider;
6. Pre-natal and preventive services. The Administration may require a contractor to provide pre-natal and preventive pediatric services, and then coordinate payment with a liable 1st or 3rd party.

D. Member or eligible person participation. A member or an eligible person shall cooperate in identifying potentially liable 1st or 3rd parties and assist the Administration, contractor, provider, nonprovider, or noncontracting provider in pursuing any 1st or 3rd party who may be liable to pay for covered services.

E. Collections.
1. The following parties shall cooperate, identify, and notify the Administration of all potential sources of 1st- or 3rd-party liability:
   a. Provider,
   b. Nonprovider, and
   c. Noncontracting provider.
2. The following parties shall pursue collection or reimbursement from all potential sources of 1st- or 3rd-party liability:
   a. The Administration,
   b. Provider,
   c. Nonprovider, and
   d. Noncontracting provider.
3. Contractors shall cooperate, identify, and notify the Administration of all potential sources of 1st- or 3rd-party liability and pursue collection or reimbursement according to R9-22-1002(B).
4. Recoveries: Contractor. A contractor may retain up to 100% of its 1st- and 3rd-party collections if:
   a. Total payments received do not exceed the total amount of the contractor's financial liability for the member. Payments in excess of the contractor's liability shall be reimbursed as described in 42 CFR 433.154;

b. AHCCCS fee-for-service, reinsurance benefits or both have not duplicated the recovery. Any duplicated benefits received shall be reimbursed to the Administration. Payments by the Administration for covered services may supplement payment or benefits from 1st or 3rd parties to the extent authorized by this Chapter or applicable contracts;
c. The recovery is not prohibited by federal or state law; and
d. The payments collected are reflected in reduced capitation rates. The Administration may require a contractor to reimburse the Administration up to 100% of collected 1st- and 3rd-party payments that are not reflected in reduced capitation rates.

5. Recoveries: Administration. The Administration may retain its 1st- and 3rd-party collections up to 100% of fee-for-service, reinsurance payments, administrative costs, capitation payments, Medicare Part A and B premium payments, and any other payments made by the System. The funds collected shall be deposited in the AHCCCS fund.

Historical Note

Former Section R9-22-712 renumbered and amended as Section R9-22-1001 effective October 1, 1985 (Supp. 85-5). Amended subsections (E) through (H) effective October 1, 1986 (Supp. 86-5). Amended subsections (B), (C), (E), and (F) effective December 22, 1987 (Supp. 87-4). Section repealed; new Section adopted effective November 7, 1997 (Supp. 97-4).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. This Section was subsequently repealed and new Section adopted under the regular rulemaking process (Supp. 97-4).

R9-22-1002. 1st- and 3rd-Party Liability Monitoring and Compliance

A. 1st- or 3rd-party liability sources. The Administration shall monitor 1st- or 3rd-party liability payments to a contractor, provider, nonprovider, or noncontracting provider, which may include but are not limited to payments by or for:
1. Private health insurance;
2. Employment related disability and health insurance;
3. Long-term care insurance;
4. Other federal programs not excluded by statute;
5. Court ordered or non-court ordered medical support from an absent parent;
6. State worker's compensation;
7. Automobile insurance, including underinsured and uninsured motorists insurance;
8. Court judgment or settlement from a liability insurer including settlement proceeds placed in a trust;
9. First-party probate estate recovery;
10. Adoption related payment; and
11. Tortfeasor.

B. Contractor responsibility. A contractor shall:
1. Recover 1st- and 3rd-party payments from the sources identified in subsections (A)(1) through (A)(5); and
2. Recover 1st- and 3rd-party payments from the sources identified in subsections (A)(6) through (A)(11), when directed by the Administration.

C. Monitoring. The Administration shall determine whether a contractor, provider, nonprovider, or noncontracting provider is in compliance with the requirements in this Article by inspecting claim submissions and payment documentation for cost avoidance and recovery activities.

D. Notification for perfection, recording, and assignment of AHCCCS liens.
1. County requirements. The county of residence shall notify the Administration according to subsection (E) within 30 days after providing services according to A.R.S. § 11-291 of charges for hospital or medical services provided to a member or eligible person for an injury or condition resulting from circumstances reflecting the probable liability of a 1st or 3rd party, so the Administration may preserve its lien rights according to A.R.S. § 36-2915.
2. Hospital requirements. Hospitals providing emergency or urgent medical services to a member or eligible person for an injury or condition resulting from circumstances reflecting the probable liability of a 1st or 3rd party shall notify the Administration according to subsection (E) within 30 days after discharge. A hospital may satisfy the requirement of this subsection also by mailing to the Administration a copy of the lien it proposes to record or has recorded according to A.R.S. § 33-932 within 30 days after discharge.
3. Contractor, provider, nonprovider, and noncontracting provider requirements. A contractor, provider, nonprovider, or noncontracting provider, other than a hospital, rendering medical services to a member or eligible person for an injury or condition resulting from circumstances reflecting the probable liability of a 1st or 3rd party shall notify the Administration according to subsection (E) within 30 days after providing the services.

E. Notification information for liens. To satisfy notification requirements, all of the following information shall be mailed to the Administration:
1. Name of the contractor, provider, nonprovider, or noncontracting provider;
2. Address of the contractor, provider, nonprovider, or noncontracting provider;
3. Name of member or eligible person;
4. Member's or eligible person's Social Security number or AHCCCS identification number;
5. Address of member or eligible person;
6. Date of member's or eligible person's admission;
7. Amount estimated to be due for care of member or eligible person;
8. Date of member's or eligible person's discharge;
9. Name of county in which injuries were sustained; and
10. Name and address of all persons, firms, and corporations and their insurance carriers claimed by the member, eligible person, or legal representative to be liable for damages.

F. Notification of health insurance information. A contractor, provider, nonprovider, or noncontracting provider shall provide notification of health insurance information to the Administration. To satisfy notification requirements, all of the following health insurance information shall be submitted to the Administration within 10 days of receipt of the health insurance information:
1. Name of member or eligible person;
2. Member's or eligible person's Social Security number or AHCCCS identification number;
3. Insurance carrier name;
4. Insurance carrier address;

5. Policy number, if available;
6. Policy begin and end dates, if available; and
7. Insured's name and Social Security number.

Historical Note

Section R9-22-529 adopted effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5). Amended subsections (C) and (D) effective October 1, 1986 (Supp. 86-5). Amended effective December 22, 1987 (Supp. 87-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed; new Section adopted effective November 7, 1997 (Supp. 97-4).

ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS

R9-22-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims

A. Circumstances for imposing a penalty and assessment. The Director or designee shall impose a penalty and assessment under the circumstances described in A.R.S. § 36-2918. For the purposes of this Article, the term "reason to know" means that a person, with respect to information, acts in deliberate ignorance of the truth or falsity of the information or with reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

B. Violation of agreement. The Director's or designee's determination of whether a person knew or had reason to know that each claim or request for payment was claimed in violation of an agreement with Arizona, the Administration, or a contractor may be based on the terms of the agreement.

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5). Amended subsection A. effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective June 9, 1998 (Supp. 98-2).

R9-22-1102. Determinations Regarding the Amount of the Penalty and Assessment

A. Factors for determining a penalty and assessment. The Director or designee shall take into account the following factors in determining the amount of a penalty and assessment:
1. The nature of each claim or request for payment and the circumstances under which it is presented or caused to be presented,
2. The degree of culpability of a person who presents or causes to present each claim or request for payment,
3. The history of prior offenses of a person who presents or causes to present each claim or request for payment,
4. The financial condition of a person who presents or causes to present each claim or request for payment,
5. The effect on patient care resulting from the failure to provide medically necessary care by a person who presents or causes to present each claim or request for payment, and
6. Other matters as justice may require.

B. Types of claim circumstances. In determining the amount of a penalty and assessment, the Director or designee shall consider both mitigating circumstances and aggravating circumstances surrounding the presentation or cause for presentation of each claim or request for payment.

C. Mitigating circumstance guidelines. The Director or designee shall consider the following mitigating circumstance guidelines when determining the amount of a penalty and assessment:
1. Nature and circumstances of each claim or request for payment. The nature and circumstances of each claim or request for payment and the circumstances under which it is presented or is caused to be presented are a mitigating circumstance if:
   a. All the items and services subject to a penalty and assessment are of the same type,
   b. All the items and services subject to a penalty and assessment occurred within a short period of time,
   c. There are few items and services, and
   d. The total amount claimed for the items and services is less than $1,000;
2. Degree of culpability. The degree of culpability of a person who presents or causes to present a claim or request for payment is a mitigating circumstance if:
   a. Each item or service is the result of an unintentional and unrecognized error in the process the person followed in presenting or in causing to present the item or service,
   b. Corrective steps were taken promptly after the error was discovered, and
   c. A fraud and abuse control plan was adopted and operating effectively at the time each claim or request for payment was presented or caused to be presented;
3. Financial condition. The financial condition of a person who presents or causes to present a claim or request for payment is a mitigating circumstance if the imposition of a penalty and assessment without reduction will jeopardize the ability of the person to continue as a health care provider. The resources available to the person may be considered when determining the amount of the penalty and assessment; or
4. Other matters as justice may require. Other circumstances of a mitigating nature will be taken into account if, in the interest of justice, the circumstances require a reduction of the penalty and assessment.

D. Aggravating circumstance guidelines. The Director or designee shall consider the following aggravating circumstance guidelines when determining the amount of a penalty and assessment:
1. Nature and circumstances of each claim or request for payment. The nature and circumstances of each claim or request for payment and the circumstances under which it is presented or caused to be presented are an aggravating circumstance if:
   a. The items and services subject to a penalty and assessment are of several types,
   b. The items and services subject to a penalty and assessment occurred over a lengthy period of time,
   c. There are many items or services (or the nature and circumstances indicate a pattern of claims for the items or services), or
   d. The total amount claimed for the items and services is $1,000 or greater;
2. Degree of culpability. The degree of culpability of a person who presents or causes to present each claim or request for payment is an aggravating circumstance if:
   a. The person knew that each item or service was not provided as claimed,
   b. The person knew that no payment could be made because the person had been excluded from System reimbursement, or
   c. Payment would violate the terms of an agreement between the person and Arizona, the Administration, or a contractor;

3. Prior offenses. The prior offenses of a person who presents or causes to present each claim or request for payment is an aggravating circumstance if, at any time before the presentation of any claim or request for payment subject to a penalty and assessment under this Article, the person was held liable for a criminal, civil, or administrative sanction in connection with:
   a. A Medicaid program,
   b. A Medicare program, or
   c. Any other public or private program of reimbursement for medical services;
4. Effect on patient care. The seriousness of an adverse effect that resulted, or could have resulted, from the failure of a person who presents or causes to present a claim or request for payment to provide medically necessary care is an aggravating circumstance; or
5. Other matters as justice may require. Other circumstances of a aggravating nature will be taken into account if, in the interest of justice, the circumstances require an increase of the penalty and assessment.

E. Amount of Penalty and Assessment. The aggregate amount of a penalty and assessment shall never be less than double the approximate amount of damages sustained by Arizona, the Administration, or contractor, unless there are extraordinary mitigating circumstances.

F. Compromise. The Director or designee may compromise a penalty and assessment using the guidelines in subsections (C) and (D).

Historical Note
Adopted effective October 1, 1986 (Supp. 86-5).
Amended effective December 13, 1993 (Supp. 93-4).
Amended effective June 9, 1998 (Supp. 98-2).

R9-22-1103. Notice of Proposed Determination and Rights of Parties

A. Administration's Responsibilities. If the Director or designee proposes to impose a penalty and assessment, the Director or designee shall deliver or send by certified mail, return receipt requested, to a person, written notice of intent to impose a penalty and assessment. The notice shall include:
1. Reference to the statutory basis for the penalty and assessment,
2. A description of each claim or request for payment for which the penalty and assessment are proposed,
3. The reason why each claim or request for payment subjects the person to a penalty and assessment, and
4. The amount of the proposed penalty and assessment.

B. Individual's Responsibilities. A person may submit within 35 days from the date of the notice of intent to impose a penalty and assessment:
1. A written statement accepting imposition of the penalty and assessment;
2. A written request for a compromise of the penalty and assessment stating any reasons that the person contends should result in a reduction or modification of the penalty and assessment. If a request is submitted, the time period for filing an appeal and request for hearing according to subsection (C) shall be tolled until the Director's or designee's decision on the request for compromise; or
3. A grievance in accordance with the provider grievance provision in Article 8 of this Chapter.

C. The Director or designee may impose a proposed penalty and assessment or any less severe penalty and assessment if a person does not request a hearing within the time prescribed by subsections (B)(2) or (B)(3). A person has no right to appeal a penalty and assessment if the person has not timely requested a hearing.

Historical Note
Adopted effective October 1, 1986 (Supp. 86-5).
Amended effective December 13, 1993 (Supp. 93-4).
Amended effective June 9, 1998 (Supp. 98-2).

R9-22-1104. Issues and Burden of Proof

A. Preponderance of Evidence. In any hearing conducted according to this Article, the Director or designee shall prove by a preponderance of the evidence that a person who requested a hearing presented or caused to be presented each claim or request for payment in violation of R9-22-1101. A person who requests a hearing shall bear the burden of producing and proving by a preponderance of the evidence any circumstance that would justify reducing the amount of the penalty and assessment.

B. Statistical sampling.
1. The Director or designee may introduce the results of a statistical sampling study as evidence of the number and amount of claims or requests for payment that were presented or caused to be presented by the person in meeting the burden of proof described in subsection (A). A statistical sampling study shall constitute prima facie evidence of the number and amount of claims or requests for payment, if based upon an appropriate sampling and computed by valid statistical methods.
2. The burden of proof shall shift to the person to produce evidence reasonably calculated to rebut the findings of the statistical sampling study once the Director or designee has made a prima facie case as described in subsection (A). The Director or designee will be given the opportunity to rebut this evidence.

Historical Note
Adopted effective October 1, 1986 (Supp. 86-5).
Amended effective June 9, 1998 (Supp. 98-2).

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule.

R9-22-1201. Definitions

The following words and phrases, in addition to definitions contained in A.R.S. Title 36, Chapter 29, and A.A.C. Title 9, Chapter 22, Article 1, have the following meanings unless the context of the Article explicitly requires another meaning:
1. "Administration standards" means the standards established in the Title XIX state plan, federal and state statutes, and Administration rules and policies, and any subsequent amendments.
2. "Alternative residential care facilities" means ADHS-licensed Level I, II, or III facilities that are Title XIX-certified and have 16 or fewer beds.
3. "Arizona Department of Health Services (ADHS)" means the state department mandated to serve the public health needs of all Arizona residents.
4. "Case manager" means an individual certified as a behavioral health professional or a behavioral health technician, or an individual with a high school diploma or GED and a combination of 3 years of behavioral health educa-

tion and experience, supervised by a behavioral health professional or a clinical supervisor, who participates in the development of behavioral health treatment services, is responsible for developing the most cost-effective, clinically appropriate individual service plan; arranges for service provision; and monitors treatment to ensure that the behavioral health needs of the member or eligible person are met.

5. "Clinical supervisor" means an individual who meets the qualifications as defined in Laws 1992, Chapter 310.
6. "Individual service plan" means a specific plan of treatment including specific behavioral health services, service units, anticipated time frames, and provider(s) of care for an eligible person or member.
7. "Behavioral health professional" means a psychiatrist, psychologist, social worker, counselor, certified nurse practitioner, registered nurse, or physician's assistant who meets appropriate licensure and/or certification requirements.
8. "Behavioral health services" means those Title XIX covered and medically necessary treatment services for behavioral health or substance abuse disorders as set forth in Administration standards.
9. "Behavioral health technician" means an individual with a bachelor's degree in a behavioral health-related field; or a bachelor's degree in any field, plus one year of experience in a behavioral health service delivery; or a high school diploma or GED and a combination of behavioral health education and experience totaling 4 years. Behavioral health technicians shall be supervised by a behavioral health professional or a clinical supervisor.
10. "Certified nurse practitioner" means a registered nurse certified by the Arizona Board of Nursing to A.R.S. Title 32, Chapter 15.
11. "Physician's assistant" means a person who is certified by the Joint Board on the Regulation of Physician's Assistants pursuant to A.R.S. Title 32, Chapter 25. In addition, physician's assistants providing behavioral health services to eligible persons or members must have a minimum of one year of experience in a behavioral health-related field.
12. "Psychiatrist" means a psychiatrist who is professionally licensed pursuant to A.R.S. Title 32, Chapter 13 or Chapter 17, Board certified or Board eligible under the standards of the American Board of Psychiatry and Neurology or the Osteopathic Board of Neurology and Psychiatry.
13. "Psychologist" means a person who is licensed by the Arizona Board of Psychologist Examiners pursuant to A.R.S. Title 32, Chapter 19.1.
14. "Referral" means directing, as appropriate, an eligible person or member requiring behavioral health services to a RBHA or contractor for screening, evaluation, and treatment.
15. "Regional Behavioral Health Authority" (or "RHBA") means an organization under contract with ADHS to coordinate the delivery of behavioral health services in a geographically specific service area of the state.
16. "Registered nurse" means a person who is licensed by the Arizona Board of Nursing pursuant to A.R.S. Title 32, Chapter 15. In addition, registered nurses providing behavioral health services to eligible persons or members must have a minimum of one year of experience in a behavioral health-related field.
17. "Seriously Mentally Ill" (or "SMI") means adult persons whose emotional or behavioral functioning is so impaired as to interfere with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. The mental disability is severe and persistent and may result in a long-term limitation of their functional capabilities for primary activities of daily living, interpersonal relationships, homemaking, self-care, employment, or recreation. The mental impairment may limit their ability to seek or receive local, state, or federal assistance such as housing, medical and dental care, rehabilitation services, income assistance, and food stamps or protective services. Although persons with primary diagnoses of mental retardation, head injuries, senile dementia, or Alzheimer's Disease frequently have similar problems or limitations, they are not to be included in this definition.
18. "Substance abuse" means the chronic, habitual or compulsive use of any chemical matter which, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological or physiological dependence and/or impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse.
19. "Title XIX" means Title XIX of the Social Security Act, as amended, which is the federal statute authorizing Medicaid.
20. "Treatment" means the range of behavioral health care received by an eligible person or member that is consistent with the therapeutic goals outlined in the individual service plan.
21. "Tribal government" means the recognized governing body of any federally recognized tribe in Arizona. A tribal government may be any legally established organization of American Indians which is controlled, sanctioned or chartered by the above governing body, or which is democratically elected by the adult members of the American Indian community to be served by such an organization.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4).

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R9-22-1202. Eligibility

All categorically eligible persons and members with a behavioral or substance abuse disorder shall be eligible for covered services set forth in R9-22-1204.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of

State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4).

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R9-22-1203. Service Delivery System and Referral

A. The Arizona Department of Health Services (ADHS) shall be responsible, pursuant to A.R.S. § 36-2907, for the provision of medically necessary behavioral health services set forth under this Article to categorically eligible persons and members under 18 years of age, SMI adults 18 years of age and older, and non-SMI adults 21 years of age or older.
1. ADHS shall contract with RBHAs for the provision of behavioral health services set forth in R9-22-1204 to eligible persons and members.
2. RBHAs shall arrange for the availability of covered behavioral health services through contracts with qualified services providers within and, if unavailable, outside their service areas.

B. ADHS may contract with federally recognized tribal governments for the provision of behavioral health services to eligible persons and members. In the absence of such contracts, eligible persons or members who are enrolled in the Indian Health Service (IHS) may receive on-reservation behavioral health services through the IHS or the eligible person or member may be referred off-reservation to the RBHA which is responsible for the provision of covered behavioral health services off-reservation.

C. Contracts shall be responsible for:
1. The provision of covered behavioral health services to non-SMI categorically eligible persons and members 18 through 20 years of age; and
2. The referral of members under 18 years of age, SMI adults 18 years of age and older, and non-SMI adults 21 years of age and older to RBHAs in accordance with standards established by the Director.

D. The Administration shall provide appropriate authorizations and services for 18- through 20-year-old, non-SMI-eligible persons not enrolled with a contractor.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4).

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R9-22-1204. Covered Behavioral Health Services for Eligible Persons and Members

A. The following general service requirements apply with respect to behavioral health services provided under this Article, subject to all applicable exclusions and limitations.
1. The service shall be medically necessary, cost effective and Title XIX reimbursable.
2. The service shall be provided by qualified service providers pursuant to R9-22-1205.
3. Service providers, as applicable, shall contract with the RBHAs or contractors.
4. Services shall be authorized, as applicable, by the RBHA or contractor and shall be consistent with prior authorization, federal certification of need and inspection of care requirements and utilization review standards established by the Director.
5. The person shall be eligible for Title XIX on the date the service is provided and shall not be in an institution for mental diseases (IMD) unless the eligible person or member is under 21 years of age and in a Title XIX participating inpatient psychiatric facility, or 65 years of age or older and in a Title XIX participating IMD.
6. Services shall be provided in appropriate residential settings which meet state and federal licensing standards.

B. The following behavioral health services shall be covered, subject to the limitations and exclusions in this Article, and further subject to approval by the Health Care Financing Administration.
1. Inpatient services, including:
   a. Inpatient hospital services for treatment of acute episodes, generally of a short duration, in participating acute general hospitals.
   b. Inpatient psychiatric facility services under the direction of a psychiatrist for persons under 21 years of age in a residential treatment center (RTC) or an inpatient psychiatric hospital accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO).
   c. IMD services under the direction of a psychiatrist for persons 65 years of age or older in an inpatient psychiatric hospital or nursing care facility providing diagnosis, medical attention, nursing care and related services to persons with mental disease.
   d. Limitations:
      i. Room and board is not a covered service in residential settings except for inpatient services as set forth in subsection (B)(1).
      ii. Inpatient substance abuse services initially may be authorized for up to 4 days of medically necessary detoxification. If medically necessary, additional days subsequently may be authorized if ordered by a physician and approved by the RBHA, the contractor's Medical Director, or the Administration.
2. Professional services, including:
   a. Individual therapy and counseling provided by a behavioral health professional or a behavioral health technician in face-to-face interaction with the eligible person or member.
   b. Group and/or family therapy/counseling provided by a behavioral health professional or a behavioral health technician in face-to-face interaction with the

eligible person or member and his/her family, and/or spouse, or other group.

c. Psychotropic medication adjustment and monitoring which includes prescriptions, review of the effects and side effects of psychotropic medications, and adjustment of the type and dosage of medication provided by a psychiatrist; or a physician's assistant, certified nurse practitioner, or registered nurse under the direction of a physician.

d. Limitations: Only psychiatrists and psychologists may bill independently for services provided. Other behavioral health professionals and behavioral health technicians shall be affiliated with a qualified agency such as a rehabilitation or clinic agency or an inpatient or outpatient hospital, RTC, or an alternative residential care facility and services provided by these individuals shall be billed through that agency.

3. Rehabilitation services, including:
   a. Basic partial care services which are provided by a behavioral health professional or a behavioral health technician following residential or inpatient treatment, or to prevent placement in a more restrictive setting. Basic partial care services are provided within a structured, coordinated, and continuous program of goal-oriented therapeutic activities.
   b. Intensive partial care services which are provided by a behavioral health professional or a behavioral health technician as an alternative to inpatient care. Intensive partial care services are a planned, structured, and coordinated program of intensive care, which are scheduled on a regular basis, providing active treatment for full or partial resolution of the eligible person's or member's acute or episodic behavioral health problems and includes on-site visits with a psychiatrist.
   c. Emergency/crisis behavioral health services provided by a behavioral health professional or a behavioral health technician. Emergency/crisis behavioral health services are immediate and intensive, time-limited, community-based, face-to-face crisis interventions and resolution services which are available on a 24-hour basis in situations where an eligible person or member is a danger to self or others.
   d. Behavior management services provided by a behavioral health professional or a behavioral health technician. Behavior management services primarily involve direct patient behavior management and may also include services related to activities of daily living and household services incidental to and consistent with the behavioral health rehabilitation needs of the eligible person or member.
   e. Psychosocial rehabilitation services provided by a behavioral health professional or a behavioral health technician. Psychosocial rehabilitation services are a comprehensive program of active treatment, including activities of daily living, training in communication, and assistance with psychotropic medication.
   f. Limitations:
      i. Intensive partial care services shall be limited to eligible persons or members whose emotional, behavioral, or substance abuse problems indicate a serious emotional disturbance and/or evidence of abuse or neglect.
      ii. Prevocational or vocational activities and school attendance educational hours are not included in intensive and basic partial care services and may not be billed simultaneously with these services.
      iii. Emergency/crisis behavioral health services are limited to emergencies or crises as defined in R9-22-101.
4. Evaluation and case management services, including:
   a. Screening provided by a behavioral health professional or a behavioral health technician. Screening is an in-person interaction with the eligible person or member to determine the need for behavioral health services and the assignment of the eligible person or member for further evaluation, diagnosis, or care and treatment.
   b. Evaluation services provided by a behavioral health professional or a behavioral health technician. Evaluation is the assessment of the eligible person's or member's medical, psychiatric, psychological, or social conditions to determine if a mental disorder exists and, if so, to provide diagnosis for the direction of care.
   c. Case management services. Case management consists of a set of services and activities through which appropriate and cost-effective Title XIX covered services are identified, planned, coordinated, obtained, monitored, and continuously evaluated.
   d. Limitations:
      i. Screening services are limited to no more than once for every 6-month period of continuous behavioral health services.
      ii. Reimbursement for evaluation services and non-emergency medication monitoring provided to SMI-eligible persons or members is included in the clinical case management per diem rate and must not be billed separately. An SMI clinical case management team member must not bill independently for the delivery of behavioral health services.
      iii. SMI clinical case management services shall only be provided by a RBHA to SMI-eligible persons or members.
5. Behavioral health-related services, including:
   a. Psychotropic medications defined by the ADHS Title XIX formulary or contractor formulary, as appropriate.
   b. Laboratory and radiology services provided by medical laboratories and outpatient hospitals, which are used to regulate and monitor psychotropic medications and to diagnose mental illnesses.
6. Transportation services which include emergency and medically necessary transportation to and from settings providing behavioral health services. Limitations:
   a. Medically necessary transportation must be prior authorized as applicable by the RBHA or contractor.
   b. Emergency and medically necessary transportation services must be provided in accordance with R9-22-211.
   c. Emergency transportation is limited to situations where there is an imminent threat of harm to the eligible person or member if care is not rendered expeditiously.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to

Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective January 1, 1996; filed with the Secretary of State December 22, 1995 (Supp. 95-4).

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R9-22-1205. Qualifications and Standards of Participation for Service Providers

A. To provide behavioral health services to eligible persons or members, qualified service providers shall, at a minimum:
1. Be employed by or contracted in writing with either a RBHA or a contractor to provide behavioral health services to eligible persons or members.
2. Have all applicable state licenses or certifications or comply with alternative requirements established by the Administration;
3. Register with the Administration as a service provider;
4. Comply with all applicable criteria under A.A.C. Title 9, Chapter 22, Article 5, and this Article.

B. Utilization control.
1. Service providers shall cooperate with utilization review and quality management programs of the RBHA, contractors, the ADHS and the Administration.
2. Service providers shall comply with applicable procedures set forth in 42 CFR 456, incorporated by reference herein and on file with the Office of the Secretary of State.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4).

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R9-22-1206. Payments

A. All payments to ADHS and contractors shall be made pursuant to the terms and conditions of agreements executed with the Administration in accordance with requirements set forth in A.A.C. Title 9, Chapter 22, Article 7, unless otherwise specified in this Article.

B. ADHS shall receive a monthly capitation payment, based on the number of acute care categorically eligible persons and members at the beginning of each month, in accordance with standards established by the Administration. Administrative costs shall be incorporated into the capitation payment.

C. Contractors shall be paid for behavioral health services provided to enrolled non-SMI members 18 through 20 years of age through a capitation adjustment in their contract with the Administration.

D. Claims submissions
1. Contracted service providers shall submit clean claims to ADHS or its designated representative, as specified in the ADHS contract with the Administration.
2. Payments for fee-for-service claims for non-SMI eligible persons 18 through 20 years of age submitted to the Administration shall be limited to amounts that do not exceed the capped fee schedule adopted by the Administration, adjusted for third-party payments. The fee schedule is on file at the central office of the Administration.
3. Claims submitted to contractors and the Administration for non-SMI members or eligible persons 18 through 20 years of age shall comply with the time-frames and other applicable procedures set forth in Article 7.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4).

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R9-22-1207. Grievance and Appeal Process

A. All grievances relating to any adverse action, decision, or policy regarding behavioral health issues shall be processed in accordance with standards by the Administration pursuant to contract with the ADHS, contractors, and provider agreements.

B. An appeal of a grievance decision under this Article shall be conducted as a contested case pursuant to A.A.C. Title 9, Chapter 22, Article 8 and the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6, Article 6).

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4).

ARTICLE 13. MEMBERS' RIGHTS AND RESPONSIBILITIES

R9-22-1301. General Intent and Definitions

A. This Article defines the notice and appeal process when the Administration or a contractor reduces, suspends, or terminates a service and provides a party with the opportunity for an expedited hearing.

B. Definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "Action" means termination, suspension, or reduction of a covered service as defined in R9-22-102.
2. "Contractor" means a health plan, ALTCS program contractor, the Arizona Department of Health Services, or a Regional Behavioral Health Authority.
3. "Date of action" means the effective date for a termination, suspension, or reduction.
4. "Denial" means the decision not to authorize a requested service.
5. "Notice" means a written statement that meets the requirements specified in R9-22-1304.
6. "Party" means a member, contractor, or the Administration.
7. "Request for a hearing" means a clear expression by a member or a member's authorized representative that the member wants the opportunity to present the member's case to a reviewing authority.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

R9-22-1302. Denial of a Request for a Service

The Administration or a contractor shall provide a member with written notice no later than 3 business days from the date when authorization for a requested service is denied by the party giving notice.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

R9-22-1303. Reduction, Suspension, or Termination of a Service

Except as permitted under R9-22-1305 and R9-22-1306, if the Administration or contractor reduces, suspends, or terminates a service currently provided by the Administration or contractor, the Administration or contractor shall provide the member written Notice of Intended Action at least 10 days prior to the effective date of the intended action.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

R9-22-1304. Content of Notice

A Notice of Intended Action, required under R9-22-1302 or R9-22-1303 of this Article, shall contain the following:

1. A statement of the action the Administration or a contractor intends to take;
2. The succinct and specific reason for the intended action;
3. The specific law or rule that supports the action;
4. A change in federal or state law that requires an action;
5. An explanation of:
   a. A member's right to request an evidentiary hearing; and
   b. The circumstances under which the Administration or a contractor shall grant a hearing for an action based on a change in the law; and
6. An explanation of the circumstance under which the Administration or a contractor shall continue a covered service if a member appeals an action for a:
   a. Reduction,
   b. Suspension, or
   c. Termination of a service.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

R9-22-1305. Exceptions from an Advance Notice

The Administration or a contractor may mail a Notice of Intended Action for a reduction, suspension, or termination of a service not later than the date of action if the Administration or a contractor:

1. Has factual information confirming the death of a member;
2. Receives a written statement signed by the member that:
   a. States services are no longer wanted; or
   b. Provides information which requires a reduction or termination of a service and indicates that the member understands that a reduction or termination of a service shall be the result of providing that information;
3. Learns that a member has been admitted to an institution which makes the member ineligible for services;
4. Does not know the member's whereabouts and mail directed to the member is returned by the post office and no forwarding address is provided;
5. Has established the fact that the member has been approved for Medicaid services outside the state of Arizona;
6. Knows that a member's primary care provider has prescribed a change in the level of medical care; or
7. Knows the Notice of Intended Action involves an adverse determination for preadmission screening requirements specified in A.R.S. § 36-2936 for an ALTCS member.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

R9-22-1306. Notice in a Case of Probable Fraud

The Administration or a contractor may shorten the advance notice period to 5 days before the date of action if:

1. The circumstances indicate that action should be taken because of probable fraud by a member; and
2. The facts have been verified through collateral resources, if possible.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

R9-22-1307. Expedited Hearing Process

A. Alternative hearing process. This Section provides an alternative expedited hearing process for denials defined in R9-22-1301(B)(4) and an alternative expedited hearing process and continued services for actions defined in R9-22-1301(B)(1). Except as stated in this Section, the provisions of 9 A.A.C. 22, Article 8 do not apply. If the Administration determines that a request for hearing filed according to this Section is not timely or not a proper appeal of a denial or action as defined in R9-22-1301(B), the request for hearing shall instead be considered a grievance according to 9 A.A.C. 22, Article 8 and, if appropriate, forwarded to the contractor within 10 business days from the date the Administration receives the request for processing according to 9 A.A.C. 22, Article 8. In this event, services shall not be continued as provided in this Section. If a member does not seek continued services or an expedited hearing, the member may file a grievance according to 9 A.A.C. 22, Article 8.

B. Time-frames. If the Administration or a contractor denies a service that requires authorization or reduces, suspends, or terminates existing service; and the member appeals the action and requests continued services during the hearing process or requests an expedited hearing of a denial for authorization, a member must file a request for hearing:
1. No later than 10 business days from the date of personal delivery of the Notice of Intended Action to the member; or
2. No later than 15 business days from the postmark date, if mailed, of the Notice of Intended Action.

C. Expedited hearing. A hearing under this Section shall be held no sooner than 20 days and not later than 40 days from the Administration's receipt of the request for hearing. Alternatively, the hearing may be held sooner than 20 days upon the agreement of all of the parties or upon written motion of 1 of the parties establishing, in the discretion of the Administration, extraordinary circumstances or the possibility of irreparable harm if the hearing is not held sooner.

D. Notice of hearing date. The Administration shall provide notice of the hearing date to the member or the authorized representative and to all other parties to the appeal.

E. Responsibilities of the Administration or a contractor. The Administration or a contractor shall provide the current level of an existing service during the expedited hearing process, if a request for expedited hearing and request to continue services are properly filed according to this Section.

F. Previously authorized service:
1. If a member's primary care provider orders a service that was previously authorized for the member, the Administration or a contractor may issue a written denial according to R9-22-1302, if the Administration or a contractor considers the request new and independent of any previous authorization. If the member's primary care provider asserts that the requested service or treatment is a necessary continuation of the previous authorization, and the member challenges the denial on this basis, then the service shall be continued pending appeal, unless:
   a. The parties reach some other agreement, or
   b. The Administration or contractor believes the primary care provider's request endangers the member.
2. Any dispute regarding reimbursement of a service under this Section is reserved until the provider submits a claim.

G. Responsibility of a member. A member whose service is continued during the expedited hearing process is financially liable for the service received if the Director upholds the decision to reduce, suspend, or terminate the service.

H. General provisions. The expedited hearing process shall be conducted according to R9-22-801 subsections (A) through (E) and (G) through (M).

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

R9-22-1308. Maintenance of Records
The party providing Notice of Intended Action shall maintain records of the written notification and the date of the notice given to the member.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

R9-22-1309. Member Handbook
A contractor shall furnish each member with a handbook, as specified in contract, that explains a member's right to file a grievance or appeal concerning a denial or action that affects a member's receipt of medical services.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

ARTICLE 14. TITLE IV-A RELATED ELIGIBILITY

R9-22-1401. Scope and Applicability

A. This Article applies to all eligibility coverage groups listed in R9-22-1406 unless otherwise specified.

B. To qualify for medical assistance under this Article, a person shall be:
1. A child under age 18, or age 18 and meeting student requirements defined in R9-22-1406;
2. A parent or nonparent caretaker relative of a deprived child if the child meets the requirement in subsection (B)(1); or
3. A pregnant woman.

C. The eligibility requirements for a person who is age 65 or older, blind, or disabled are specified in Article 15.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1402. Agency Responsible for Determining Eligibility
The Department shall determine eligibility under the provisions of this Article for all persons listed in R9-22-1401(B) who apply for medical assistance under this Article.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22 -1403. Confidentiality
The confidentiality provisions in A.A.C. R6-12-102 apply to this Article.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1404. Case Record

A. The Department shall maintain a case record for each applicant and recipient of medical assistance.

B. The case record shall contain all documentation collected or prepared by the Department in evaluating and determining eligibility.

C. The Department shall keep the case record for 3 years after the date of the last Notice of Action sent by the Department denying or terminating eligibility.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1405. Manuals
FAA shall maintain a copy of the Medical Assistance Program eligibility policy material in each FAA office and make the material available for public inspection and copying during regular business hours.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1406. Eligibility Coverage Groups and an Eligible Person

A. General eligibility. The Department shall evaluate eligibility under this Article for any person listed in R9-22-1401(B). To be eligible, a person shall meet all the eligibility requirements in this Article, except as otherwise specified. The coverage groups defined in this Section are authorized in A.R.S § 36-2901.4(b).

B. The 1931 coverage group.
1. The 1931 groups includes families who meet the eligibility provisions of Section 1931 of the Social Security Act, 42 U.S.C. 1396u-1, July 1, 1997, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
2. If determining eligibility under the 1931 group, the Department shall include the following persons, if living together, in the assistance unit:
   a. A dependent child under age 18;
   b. A dependent child age 18 who is:
      i. A full-time student in a secondary school, or the equivalent level of vocational or technical training school, as provided in subsection (B)(5); and
      ii. Reasonably expected to complete the education or training before age 19;
   c. The parent of a dependent child; and
   d. A dependent child's sibling who is:
      i. Under age 18; or
      ii. Age 18 and meets the student requirements under subsection (B)(2)(b).
3. The Department may include a nonparent caretaker relative meeting the requirements specified in R9-22-1418 if:
   a. The nonparent caretaker relative provides a dependent child with physical care, support, guidance, and control; and
   b. The parent of a dependent child:
      i. Does not live in the nonparent caretaker relative's home;
      ii. Lives with the nonparent caretaker relative but is also a dependent child; or
      iii. Lives with the nonparent caretaker relative but cannot function as a parent due to a physical or mental impairment.
4. An applicant in the last trimester of pregnancy, with no other dependent children, may be eligible for medical assistance under the 1931 group as though the child was already born. The Department shall consider the unborn child to be a dependent child.
5. Full-time school attendance as specified in subsection (B)(2)(b) means:
   a. For secondary school, attendance which the school defines as full-time; or
   b. For a vocational or technical school which:
      i. Includes shop practicum, attendance is 30 hours per week; or
      ii. Does not include shop practicum, attendance is 25 hours per week.
6. The Department shall verify school attendance as provided in subsection (B)(2)(b), through school records to establish full-time attendance status and expected date of graduation.

C. Four-month continued-coverage group. If the collection of court-ordered spousal maintenance, division of income, alimony, or child support under Title IV-D of the Act results in ineligibility for medical assistance under the 1931 group, the Department shall provide 4 consecutive calendar months of medical assistance under the provisions of Section 1931(c) of the Social Security Act, 42 U.S.C. 1396u-1, July 1, 1997, and 42 CFR 435.115(f) and (g), December 21, 1990, incorporated by reference and on file with the Administration and the Secretary of State. These incorporations by reference contain no future editions or amendments.

D. Title IV-E adoption subsidy or Title IV-E foster care coverage groups.
1. The Title IV-E coverage groups include a child:
   a. For whom an adoption assistance agreement is in effect under Title IV-E of the Act; or
   b. Who receives a foster care maintenance payment under Title IV-E of the Act;
2. A child meeting the provisions of subsection (D)(1) shall also meet the eligibility requirements specified in R9-22-1422 through R9-22-1424.

E. State adoption subsidy coverage group. The state adoption subsidy coverage group includes a child meeting the provisions of 42 CFR 435.227, December 21, 1990, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

F. Transitional medical assistance (TMA) group.
1. Except as provided in subsection (F)(2), the Department shall determine initial and ongoing eligibility in the TMA group for the 1931 assistance unit who meets the eligibility provisions of 42 U.S.C. 1396a(e)(1), July 1, 1997, and 42 U.S.C. 1396r-6, August 5, 1997, except for the options defined in Section 1925(a)(4)(B) of the Act, incorporated by reference and on file with the Administration and the Secretary of State. These incorporations by reference contain no future editions or amendments.
2. The Department may determine the assistance unit eligible for TMA for a period not to exceed:
   a. 24 months; or
   b. 12 months, if the Department assigns the TMA case to a control group as provided in A.A.C. R6-12-105(A), (B), and (C); and
3. The Department shall collect semi-annual income reports in lieu of quarterly income reports.
4. To qualify for medical assistance under TMA, a person shall be:
   a. An eligible member of a 1931 family at the time eligibility changes from the 1931 group to the TMA group under subsection (F)(1); or
   b. A person who moves into the household and can be included in the TMA assistance unit specified in R9-22-1419.

G. 210 coverage group. To be eligible for the 210 group, a person shall meet all the eligibility requirements for the 210 group defined in this Article and shall be:
1. A caretaker relative who is a natural or adoptive parent meeting the requirements of R9-22-1418 or who is a nonparent caretaker relative meeting the requirements of subsection (B)(3); or
2. A dependent child, age 18, who meets the student requirements of subsection (B)(2)(b).

H. Ribicoff group. The Ribicoff group includes a child under age 18 who meets all the eligibility requirements under this Article except for R9-22-1418 and R9-22-1420.

I. S.O.B.R.A. FPL pregnant woman coverage group.
1. The S.O.B.R.A. FPL pregnant woman group provides medical assistance through the postpartum period, as specified in R9-22-1434, to a pregnant woman whose monthly income does not exceed 140% of the FPL income standard.
2. A change in income during the time a woman is eligible for and receiving medical assistance under this subsection shall not affect the woman's continued eligibility for the S.O.B.R.A. FPL pregnant woman group.

J. S.O.B.R.A. FPL children coverage group. The S.O.B.R.A. FPL children group includes children born on or after October

1, 1983, whose monthly income does not exceed the following FPL income standard:
1. For children under age 1, 140% of the FPL;
2. For children age 1 through age 5, 133% of the FPL; and
3. For children age 6 and over, 100% of the FPL.

K. Deemed newborn group. The deemed newborn group includes children meeting the requirements specified in R9-22-1433.

L. Guaranteed enrollment coverage group. The guaranteed enrollment group includes persons meeting the requirements specified in R9-22-1704.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1407. Application

A. Right to apply. A person may apply for medical assistance by submitting a Department-approved application to any FAA office or outstation location as specified in subsection (C).

B. Who may apply for the applicant. The applicant, the applicant's parent, the applicant's legal or authorized representative, or someone acting on behalf of the applicant may file the application.

C. Applications available at outstation locations. An applicant may file an application for medical assistance at 1 of the following locations:
1. A county eligibility office as provided in A.R.S. § 36-2905. The Department shall accept the county's application form as a valid application for a S.O.B.R.A. FPL pregnant woman and a S.O.B.R.A. FPL child specified in R9-22-1406(I) and (J).
2. A BHS site as provided in Laws 1991, Chapter 213, § 21.
3. A CRS site as provided in Laws 1991, Chapter 213, § 21.
4. A Baby Arizona approved provider's office if the applicant is a S.O.B.R.A. FPL pregnant woman defined in R9-22-1406(I).
5. A FQHC or disproportionate share hospital as required by 42 CFR 435.904, October 24, 1994, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
6. Any other site determined by the Department or Administration.

D. Application date. The application date is the date an FAA office or other approved location listed in subsection (C) receives an application. An application shall contain:
1. The legible name and address of a person requesting assistance and each person for whom assistance is requested, and
2. The signature of an person making application as specified in subsection (B).

E. Complete application. A complete application shall contain:
1. Information listed in subsection (D),
2. The names of all persons living with the applicant and the relationship of those persons to the applicant, and
3. All eligibility information requested on an application form.

F. Application for cash. An application filed with the Department for cash assistance under 6 A.A.C. 12 is an application for medical assistance under this Article.

G. Deceased applicant. An application meeting the provisions of this Section, filed on behalf of a deceased applicant, is an application if the application is filed no later than the 3rd month following the applicant's date of death.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1408. Applicant and Recipient Responsibility

A. A person shall cooperate with the Department as a condition of initial and continuing eligibility.

B. The person shall:
1. Give the Department complete and truthful information;
2. Comply with the requirements of R9-22-1411 and R9-22-1415;
3. Comply with the verification requirements specified in R9-22-1413;
4. Inform the Department of the following changes which may affect eligibility within 10 days from the date the person knows of the change:
   a. A change in address,
   b. A change in the household's composition,
   c. A change in income,
   d. A change in resources,
   e. A change in Arizona state residency,
   f. A change in citizenship or alien status,
   g. A change in 1st- or 3rd-party liability which may contribute to the payment of all or a portion of the person's medical costs, and
   h. Any other change that may affect the person's eligibility;
5. Comply with the Department's procedural requirements;
6. Cooperate with the DCSE in establishing paternity and enforcing medical support obligations, unless the person shows good cause as provided in R9-22-1422; and
7. Provide information concerning 3rd-party coverage for medical care.

C. The person shall:
1. Send to the Department any medical support payments received by the person while the person is eligible for medical assistance, and
2. Comply with the quality control review process.

D. The Department may deny an application for or discontinue eligibility of medical assistance if the person fails or refuses to cooperate.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1409. Death of an Applicant

A. If an applicant dies while an application is pending, the Department shall complete an eligibility determination for all applicants listed on the application, including the deceased applicant.

B. The Department shall complete an eligibility determination on an application filed on behalf of a deceased applicant as provided in R9-22-1407.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1410. Withdrawal of Application

A. An applicant may withdraw an application at any time before the Department completes an eligibility determination by making an oral or written request for withdrawal.

B. If an applicant orally requests to withdraw the application, the Department shall:
1. Document the date of the request,
2. Document the name of the applicant for whom the withdrawal applies,
3. Deny the application, and
4. Notify the applicant of the denial following the notice requirements specified in R9-22-1414.

C. An applicant may withdraw an application in writing by:

1. Completing a Department-approved voluntary withdrawal form; or
2. Submitting a written, signed, and dated request to withdraw the application.

D. When the Department receives the written request for withdrawal, the Department shall deny the application and notify the applicant of the denial under R9-22-1414.

E. The effective date of the withdrawal is the date of the application.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1411. Initial Eligibility Interview

A. Upon receipt of an application defined in R9-22-1407(D), the Department shall:
1. Schedule an initial eligibility interview, and
2. Provide the applicant a written notice of the scheduled interview.

B. If a homebound applicant requests a home visit or a Department representative believes that a home visit will avoid an eligibility determination error, the Department shall:
1. Schedule a home visit, and
2. Mail the applicant written notice of a scheduled home visit at least 7 days before the date of the visit.

C. The applicant or the applicant's representative shall attend the interview.

D. During the interview, a Department representative shall:
1. Help the applicant complete the application form;
2. Witness the signature of the applicant or the applicant's representative as provided in R9-22-1407;
3. Provide the applicant with written information explaining:
   a. The eligibility and verification requirements of the medical assistance program;
   b. The requirement that the applicant obtain and provide a SSN to the Department;
   c. How the Department uses the SSN;
   d. The Department's practice of exchanging eligibility and income information through the SVES;
   e The applicant's rights and responsibilities, including the right to appeal an adverse action;
   f. The requirement to report a change listed in R9-22-1408 no later than 10 days from the date the applicant knows of the change;
   g. The eligibility review process;
   h. The program coverage and the types of services available under each program;
   i. The family planning services available through AHCCCS health plans;
   j. The AHCCCS pre-enrollment process; and
   k. Availability of continued medical assistance under the TMA group defined in R9-22-1406;
4. Review the penalties for perjury and fraud printed on the application;
5. Explain who is included in an assistance unit;
6. Review any verification information provided by the applicant and give the applicant a written list of additional verification that the applicant shall provide to the Department within the time-frame listed in R9-22-1413;
7. Explain the applicant's responsibilities listed in R9-22-1408; and
8. Review all reporting requirements and explain that the person may lose the earned income disregards defined in R9-22-1429 if the person fails to report changes timely.

E. If the applicant misses a scheduled appointment for an interview, or is not home for the scheduled home visit, the Department shall schedule a 2nd interview only if the applicant requests a 2nd interview before close of business on the day of the missed appointment.

F. The Department shall deny the application if the applicant fails to request a 2nd appointment under subsection (E) or if the applicant misses a 2nd scheduled appointment, unless the applicant establishes good cause for missing the appointment.

G. The Department:
1. May conduct unscheduled home visits to gather information or to verify information previously provided by an applicant, and
2. Shall not deny an application or terminate medical assistance if the applicant is not home for an unscheduled visit.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1412. Withdrawal from the Medical Assistance Program

A. A person or the person's legal or authorized representative may withdraw from the program at any time by making an oral or written request for withdrawal and providing the Department with:
1. The reason for the withdrawal,
2. The date the request is effective, and
3. The name of the person for whom medical assistance is being withdrawn.

B. If the request to withdraw does not identify a specific person, the Department shall apply the request to the entire assistance unit and terminate eligibility.

C. If the request to withdraw does not include all the members of the assistance unit, the Department shall redetermine eligibility for the remaining members under this Article.

D. The Department shall process the withdrawal action and send the recipient adequate notice as provided in R9-22-1416.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1413. Verification of Eligibility Information

A. The applicant or recipient has the primary responsibility to provide the Department with verification for all information necessary to complete the determination of eligibility at the time of application, review, or interim change.

B. The Department may assist a person in obtaining verification if the person requests help.

C. A person shall provide the Department with all requested verification no later than 10 days from the date of a written request for the information. If a person does not timely provide the requested information, the Department may deny the application or discontinue eligibility for medical assistance.

D. The Department shall obtain independent verification or corroboration of information provided by the person to determine eligibility or if required by law.

E. The Department may verify or corroborate information by any means including:
1. Contacting 3rd-parties,
2. Making home visits as provided in R9-22-1411,
3. Requiring written documentation from the person, and
4. Conducting a computer data match through SVES.

F. The application form shall advise the person that the Department may contact 3rd-parties for information.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1414. Processing the Application - Approvals and Denials

A. Application processing time. The Department shall complete an eligibility determination within 45 days after the application date defined in R9-22-1407(D), unless:
1. The application is withdrawn;
2. The Department denies the application because the Department cannot locate the applicant;
3. There is a delay resulting from a Department request for additional verification information as provided in R9-22-1413(C); or
4. The applicant is applying under the S.O.B.R.A. FPL pregnant woman group described in R9-22-1406. The Department shall complete S.O.B.R.A. FPL pregnant woman applications within 20 days after the application date.

B. Approval. If the applicant meets all the eligibility requirements of this Article, the Department shall approve the application and send the applicant an approval notice which includes:
1. The name of each approved applicant,
2. The effective date of eligibility defined in R9-22-1431 for each approved applicant,
3. The eligible months in the prior quarter period described in R9-22-1432, and
4. The applicant's appeal rights described in R9-22-1436.

C. Denial. The Department shall deny an application and send an applicant a denial notice if an applicant fails to meet all the eligibility requirements of this Article. The Department may deny an application and send an applicant a denial notice if an applicant fails to:
1. Complete the application or an eligibility interview required in R9-22-1411,
2. Submit all required verification information no later than 10 days from the date of a written request for verification, or
3. Cooperate with the requirements listed in R9-22-1408.

D. Denial notice.
1. The notice shall contain:
   a. The name of each ineligible applicant;
   b. The specific reason why the applicant is ineligible;
   c. The income and resource calculations compared to the income or resource standard applicable to the size of the assistance unit when the reason for the denial is due to the applicant's income or resources exceeding the applicable standard;
   d. The legal citations supporting the reason for the ineligibility;
   e. The physical location where the applicant can review the legal citations in subsection (D)(1)(d);
   f. The month of ineligibility including the months during the prior quarter, described in R9-22-1432, if a determination of prior quarter eligibility, completed under R9-22-1432, resulted in a denial for all months in the prior quarter; and
   g. The applicant's right to appeal the decision and request a hearing as provided in R9-22-1436.
2. The Department shall mail the notice, 1st class, postage prepaid, to the applicant's last known mailing address.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1415. Review

A. The Department shall complete a review of each person's continued eligibility for medical assistance at least once every 6 months, except for a S.O.B.R.A. FPL pregnant woman.

B. The Department shall complete a review of a S.O.B.R.A. FPL pregnant woman following the termination of her pregnancy.

C. The Department may complete a review:
1. Any time the Department receives information that a person's circumstances have changed which may affect the person's eligibility, or
2. To bring a review date in line with a 6-month review date for the Department's cash assistance or Food Stamps programs.

D. For a 6-month review, the Department shall:
1. Mail the person a notice advising the person of the need for a review at least 30 days before the 6-month review date;
2. Schedule and conduct a review interview in the same manner as an initial interview; and
3. Verify the assistance unit's income and resources, any eligibility factors which have changed, and any eligibility factors for which the Department has information suggesting a change.

E. The notice in subsection (D)(1), shall instruct the person to:
1. Contact the Department and schedule an interview to complete the review by the date specified on the review notice,
2. Complete the review application and interview, and
3. Provide verification required in R9-22-1413.

F. If a person continues to meet all eligibility requirements, the Department shall authorize continued eligibility and notify the person of continued eligibility.

G. The Department shall discontinue eligibility and shall notify the person of the discontinuance specified in R9-22-1416 and R9-22-1436 if the person:
1. Fails to comply with the review,
2. Fails to comply with the requirements specified in R9-22-1411 without good cause, or
3. Does not meet the eligibility requirements.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1416. Notice of Termination Action

A. Notice requirement. If the Department determines the recipient ineligible for medical assistance, the Department shall:
1. Send the person notice under subsections (B) and (C); and
2. Mail the notice, 1st class, postage prepaid, to the person's last known mailing address.

B. Content of notice. The notice shall contain:
1. The name of each ineligible recipient,
2. The specific reason why the recipient is ineligible,
3. The income and resource calculations compared to the income or resource standard applicable to the size of the recipient's assistance unit when the reason for the discontinuance is due to the recipient's excess income or resources,
4. The legal citations supporting the reason for the ineligibility,
5. The physical location where the recipient can review the legal citations in subsection (B)(4),
6. The date the discontinuance is effective, and
7. The recipient's appeal rights and right to continued medical assistance pending appeal provided in R9-22-1436.

C. Timing of notice.

1. Except as provided in subsection(C)(2), the Department shall mail the person an advance Notice of Action for an adverse action no later than 10 days before the effective date of the adverse action.
2. The Department may mail an adverse Notice of Action no later than the effective date of the adverse action if the Department:
   a. Receives a clear written statement signed by a person who wishes to withdraw from the program and indicates an understanding that the information provided will result in a discontinuance of medical assistance;
   b. Receives verification that the person is an inmate of a penal institution as defined in 42 CFR 435.1009, July 1, 1995, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments;
   c. Has documented information confirming the death of a person;
   d. Receives returned mail with no forwarding address from the post office and the person's whereabouts are unknown; or
   e. Verifies that the person has been approved for Medicaid coverage by another state.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1417. Reinstatement of Medical Assistance

A. The Department shall only reinstate eligibility without a new application if:
1. The discontinuance was due to Department error, or
2. The Department receives a court order or administrative hearing decision mandating reinstatement.

B. If the Department reinstates eligibility to a person who did not receive 6-month review required under R9-22-1415 due to the discontinuance of medical assistance, the Department shall conduct the review as soon as possible following reinstatement.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1418. Dependent Child Living With Specified Relative

A. The eligibility requirement that a dependent child live with a specified relative applies only to the 1931 and 210 coverage groups described in R9-22-1406(B) and R9-22-1406(G).

B. A specified relative is:
1. A natural or adoptive parent;
2. A stepparent and any other nonparent relative related by blood or adoption including:
   a. Grandmother;
   b. Grandfather;
   c. Brother;
   d. Sister;
   e. Uncle;
   f. Aunt;
   g. 1st cousin;
   h. Nephew;
   i. Niece;
   j. Persons of preceding generations as denoted by prefixes grand or great, or to the 5th degree grandparent; and
   k. 1st cousins once removed; or
3. A spouse of any person named in subsections (B)(1) or (B)(2), even if death or divorce terminates the marriage.

C. The Department shall not determine a child or specified relative ineligible solely because:
1. The dependent child is under the jurisdiction of a court;
2. An agency or applicant unrelated to the child has legal custody of the child;
3. A specified relative maintains a home for the child and exercises responsibility for the care and supervision of the child who is temporarily absent from the home for 1 of the following reasons:
   a. The child, by court order, visits a noncustodial parent for a period not to exceed 3 consecutive months;
   b. The child is visiting a parent who has a legal order awarding joint custody of the child, and the child resides with a parent who is part of the child's assistance unit for the entire calendar month;
   c. The child is living in a Department-licensed shelter which does not receive funding under Title IV-A or Title IV-E and the Department expects the child to return to the home within 30 days;
   d. During the month for which the child seeks medical assistance, the child is entering or leaving foster care funded by other than Title IV-E;
   e. The child is temporarily hospitalized;
   f. The child is visiting friends or other relatives for a period not to exceed 3 consecutive months; or
   g. The child is attending school but returns home at least once a year; or
4. The specified relative maintains a home for the child and exercises responsibility for the care and supervision of the child, and the specified relative is temporarily absent from the home for an entire calendar month or longer for 1 of the following reasons:
   a. The specified relative is temporarily hospitalized, or
   b. The specified relative is attending school and intends to return home to the child.

D. The Department shall verify the required degree of relationship between the child and the child's parent or nonparent caretaker relative.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1419. Assistance Unit

A. General requirement. This Section includes the requirements for the composition of the assistance unit for specific eligibility groups described in R9-22-1406 when the persons described in each subsection live together.

B. 1931 eligibility group.
1. The Department shall include the following persons in the assistance unit:
   a. A dependent child for whom medical assistance is requested; and
   b. Except as provided in subsections (B)(3):
      i. A natural or adoptive parent of the dependent child; and
      ii. A natural or adopted sibling who is under age 18, or age 18 and is a student as described in R9-22-1406(B);
2. The Department may include the dependent child's nonparent caretaker relative who meets the requirements specified in R9-22-1418 and R9-22-1406 when the nonparent caretaker relative also requests medical assistance;
3. The Department shall not include the following persons in the assistance unit:

a. A person who is an SSI-cash recipient; and
b. The parent or sibling of a minor parent if the minor parent is married and the minor parent's parent has relinquished all control and authority over the minor parent and no longer provides financial support to the minor parent. The Department shall not consider the married minor parent a dependent child and shall not include the married minor parent in the assistance unit of the minor parent's parent;

4. The Department shall combine more than 1 assistance unit into 1 unit if:
a. A caretaker relative applies for children who are not required to be in the same assistance unit described in subsection (B)(1)(b); and
b. The Department requires the person to be included in more than 1 assistance unit as specified in subsection (B)(1); and

5. The Department shall determine eligibility for a caretaker relative even though the only dependent child is an SSI-cash recipient or foster care child who receives foster care maintenance payments.

C. Transitional Medical Assistance (TMA) group. The Department:
1. Shall include in the TMA assistance unit eligible members of a 1931 assistance unit at the time eligibility under the 1931 eligibility group ends and the eligibility under the TMA group begins;
2. Shall add to the TMA assistance unit an eligible child's parent or sibling meeting the age requirements specified in R9-22-1406(B) and who meets the eligibility requirements under this Article.
3. Shall not add to the TMA assistance unit a person who is currently living in the home and was living in the home at the time eligibility under the 1931 eligibility group closure and the TMA group began. For example: A stepparent with no child-in-common in the home at the time of the 1931 closure is not eligible for TMA coverage even if a child-in-common is born during a TMA eligibility period. The stepparent is not eligible for TMA even though the child-in-common may be eligible.

D. Four-month continuing-coverage group. The Department shall include in the assistance unit eligible members of a 1931 assistance unit at the time of the 1931 closure and eligibility under the 4-month-continuing-coverage group begins.

E. Eligibility groups listed in R9-22-1406(G) through (J):
1. The following persons shall be included in the assistance unit:
a. The applicant, and if the applicant is pregnant, the applicant's unborn child;
b. The parent of the applicant, if the applicant is:
i. Under age 18, or
ii. Age 18 and is a student under R9-22-1406 if the Department evaluates eligibility under the 210 group specified in R9-22-1406(G), and
c. The applicant's spouse.
2. A parent or a spouse who is an SSI-cash recipient shall not be included in the assistance unit.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1420. Deprivation

A. Applicability. This Section applies only to the 1931 and 210 coverage groups described in R9-22-1406(B) and (G).

B. General. Deprivation may be caused by 1 of the factors specified in subsections (C) through (F).

C. Deprivation due to continued absence.
1. Continued absence of a parent exists:
a. When the parent is out of the home and the absence either interrupts or terminates the parent's functioning as a provider of support, physical care, or guidance for the child;
b. When the known or indefinite duration of the absence precludes relying on the parent's performance of the function of planning for the present support or care of the child; and
c. When the absence is for a period of 30 days or more for any reason other than those listed in subsection (C)(4).
2. In addition to subsection (C)(1), the following circumstances constitute evidence of deprivation by a parent's continued absence:
a. A parent is absent due to hospitalization, incarceration, or deportation;
b. A parent is a convicted offender who is permitted to live at home while serving a court-imposed sentence of performing unpaid public or community service during the work day. The Department shall consider the parent to be out of the home for the purpose of deprivation;
c. A single parent adopts a child;
d. The child's mother and putative father both dispute paternity and there is no documentation to substantiate paternity; or
e. The parents have joint legal or physical custody of the child, but the child resides with 1 parent more than 50% of the time. The child's home will be considered to be with the primary custodial parent who has the child more than 50% of the time.
3. A child who suffers deprivation under subsection (C)(1) shall not be denied a finding of deprivation based on any 1 of the following:
a. A stepparent, nonparent caretaker relative, or adult who is not the child's parent, resides in the child's home;
b. The child's home is considered unsuitable because of neglect, abuse, or exploitation;
c. The parent or nonparent caretaker relative refuses to cooperate with the Department regarding Title IV-D medical support enforcement or collection; or
d. The absent parent visits the child.
4. A finding of continued absence shall not be established if:
a. The parent is voluntarily absent to visit friends or relatives, to seek employment, to maintain a job, to attend school or training, as long as the parent in the home and the absent parent are not separated;
b. The parent is absent due to active military duty;
c. The parents live in separate dwellings and such dwellings are considered part of a single home; or
d. One parent is absent from home in order to qualify the remaining family members for medical assistance.

D. Deprivation due to death. A child is deprived if either parent of the child is deceased.

E. Deprivation due to incapacity or disability.
1. A child is deprived if either the natural or adoptive parent has a physical or mental illness or impairment that:
a. Substantially decreases or eliminates the parent's ability to support or care for the child, and
b. Is expected to last for a minimum of 30 continuous days.
2. Existence of disability.

a. The local FAA eligibility interviewer shall establish incapacity, without further medical verification, if the applicant provides evidence that:
i. SSA determines the parent is eligible for Retirement, Survivors, Disability Insurance (RSDI) benefits due to blindness or disability;
ii. SSA determines the parent is eligible for SSI due to blindness or disability;
iii. Veteran's Administration determines the parent has a 100% disability;
iv. The parent's physician releases the parent from the hospital and imposes work restrictions for a specified recuperation period;
v. The parent's employer or physician requires the parent to suspend work activity due to the onset of a disability and the physician specifies a recuperation period;
vi. The parent's physician determines the parent is capable of employment only in a sheltered workshop for a specified period of time, and the parent is employed in the sheltered workshop; or
vii. A prior certification of disability is in the assistance unit's case record and is still valid to cover the period for which the assistance unit requests and will receive assistance.
b. The assistance unit shall demonstrate incapacity of a parent by providing a medical statement from a licensed physician. The statement shall include:
i. A diagnosis of the parent's medical condition,
ii. A finding that the parent has a physical or mental condition which prevents the parent from working, and
iii. An opinion concerning the duration of unemployability or a date for re-evaluation of unemployability.

3. The District Medical Consultant shall determine incapacity for all applicants not covered under subsection (E)(2).

F. Unemployment in a 2-parent household.

1. A child is deprived if the primary wage-earning parent is unemployed and the assistance unit meets the following requirements:
a. The child's natural or adoptive mother and father both reside with the child,
b. Neither parent meets the provision of subsection (E), and
c. The assistance unit's countable income does not exceed the income standards provided in R9-22-1430(B).
2. The primary wage-earner means whichever parent in a 2-parent household earned the greater amount of income in the 24-month period immediately preceding the month in which an application for medical assistance is filed.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1421. Application for Other Benefits
An applicant or recipient shall apply for other benefits under 42 CFR 435.608, August 18, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1422. Assignment of Rights; Cooperation

A. General requirement. As a condition of eligibility under this Article, the person shall:
1. Assign to the state any rights, or the rights of any other person eligible under the medical assistance program for whom a legal assignment may be made for medical support and for payment of medical care from any 3rd-party, except for Medicare benefits.
2. Comply with the cooperation requirements defined in this Section.

B. Method of assignment.
1. The method of assignment for medical support shall be made under A.R.S. § 46-407. A medical support obligation available under a court order includes any unpaid medical support obligation or support debt which has accrued at the time of the assignment.
2. The method of assignment to payment for medical care from any 1st- or 3rd-party is the application form for medical assistance. The signature on the application of the person identified in subsection (A)(1) fulfills the assignment-of-rights requirement.

C. Cooperation with the Department or the Administration for 1st-and 3rd-party payments.
1. A person described in subsection (A)(1) shall cooperate with the Department and the Administration in identifying and providing information to assist the state in pursuing any 1st or 3rd party who may be liable to pay for medical care and services provided under the medical assistance program.
2. A person shall pay to the Administration any payment received by the assistance unit that the assignment covers.

D. Cooperation with the Department for pursuing medical support.
1. Except as provided in (D)(2) and A.R.S. § 46-292(E) and (F), a parent, legal representative, or other relative who applies for medical assistance on behalf of a child shall cooperate with the Department (DCSE) to:
a. Establish paternity, and
b. Obtain medical support or other payments as provided in A.R.S. § 46-292(C).
2. A S.O.B.R.A. FPL pregnant woman defined in R9-22-1406 is exempt from cooperating with the Department (DCSE) in establishing paternity and obtaining medical support from a father of a child born out-of-wedlock.

E. Department responsibility. At an initial application interview and at any review, the Department shall:
1. Explain to the person:
a. The assignment of rights,
b. The requirement to cooperate,
c. Good cause for not cooperating and how to establish it,
d. The consequences of failure to cooperate with the requirements of this Section,
e. That the Department will use the information requested in subsection (E)(2)(b) to complete data matches with potential liable parties including those described in R9-22-1413(E)(4),
f. The requirement to send to the Department any medical support the assistance unit receives after approval for medical assistance, and
g. The requirement to send to the Administration any payment received from any liable party for a person's medical care.
2. Obtain from the person:
a. Health insurance information, if applicable:

i. Name of policy holder,
ii. Policy holder's relationship to the applicant,
iii. SSN of the policy holder,
iv. Name and address of the insurance company,
v. Policy number; and

b. The name and SSNs of absent or custodial parents of a child for whom medical assistance is requested.

F. Failure to cooperate.

1. The Department shall deny or discontinue eligibility for a person defined in subsection (B) who:
   a. Refuses to comply with the assignment requirements defined in this Section, or
   b. Refuses to cooperate as required in subsections (C) and (D).
2. The Department shall not deny medical assistance to any person who:
   a. Cannot legally assign rights under subsection (B)(2), and
   b. Who would otherwise be eligible for the program.
3. The Department shall comply with the notice and hearing requirements of R9-22-1414, R9-22-1416, and R9-22-1436 if denying or discontinuing medical assistance under this Section.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1423. Social Security Number

A. Except as provided in subsection (B), an applicant shall furnish a SSN as provided in 42 CFR 435.910, May 29, 1986, and 42 CFR 435.920, May 29, 1986, incorporated by reference and on file with the Administration and the Secretary of State. These incorporations by reference contain no future editions or amendments.

B. An undocumented alien is not required to furnish a SSN.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1424. State Residency

To be eligible under this Article, a person shall be a resident of Arizona as provided in 42 CFR 435.403, December 21, 1990, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1425. Citizenship and Alien Status

A. An applicant shall be either:
1. A citizen of the United States, or
2. A qualified alien under A.R.S. § 36-2903.03.

B. The Department shall verify alien status by obtaining an applicant's alien registration documentation, or other proof of immigration registration, from the U.S. Immigration and Naturalization Service (INS), or by submitting an applicant's alien registration number and other related information to the INS for verification of alien status.

C. An alien who does not qualify under subsection (A) and who meets all other eligibility requirements shall only receive emergency medical services as defined in R9-22-217.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1426. Resources

A. Evaluation of resources. In determining eligibility for the 1931, 210, and Ribicoff groups described in R9-22-1406, the Department shall evaluate all resources under the provisions of this Section.

B. Included resources. The Department shall include the resources belonging to the persons listed in this subsection:
1. Members of the assistance unit defined in R9-22-1419,
2. The spouse of a nonparent caretaker relative if the nonparent caretaker relative is included in the assistance unit, and
3. Sponsor and sponsor's spouse of a person who is a qualified alien under A.R.S. § 36-2903.03.

C. Ownership and availability. The Department shall evaluate the availability of resources to the person listed in subsection (B) based on ownership.
1. Jointly-owned resources, with ownership records containing the words "and" or "and/or" between the owners' names, are available to each owner except if 1 of the owners refuses to sell. A consent to sale is not required if all owners are members of the assistance unit.
2. Jointly-owned resources, with ownership records containing the word "or" between the owners' names, are available in full to each owner.
3. The sole and separate property of 1 spouse is unavailable to the other spouse.

D. Unavailability. The Department shall consider the following resources unavailable:
1. Property subject to spendthrift restriction, which may include:
   a. Irrevocable trust funds; or
   b. Accounts established by the SSA, Veteran's Administration, or similar sources which mandate that the funds in the account be used for the benefit of a person not residing with the assistance unit;
2. Resources being disputed in divorce proceedings or in probate matters; and
3. Real property located on a Native American reservation.

E. Resource exclusion. The Department shall exclude the following resources:
1. The primary residence of the person listed in subsection (B);
2. One burial plot for each person listed in subsection (B);
3. Household furnishings and personal items which are necessary for day-to-day living;
4. Up to $1500 of the value of 1 bona fide funeral agreement, for each person listed in subsection (B);
5. The value of 1 motor vehicle regularly used for transportation. If the assistance unit owns more than 1 vehicle, the exclusion is applied to the vehicle with the highest equity value, and the equity value of all remaining vehicles is counted toward the resource limit in subsection (B), subject to the limitations described in this Section;
6. A vehicle used to produce income;
7. The value of any vehicle in which the SSI recipient has an ownership interest;
8. The value of any vehicle used for medical treatment, employment, or transportation of a SSI disabled child, and which is excluded by SSI for that reason;
9. The person in subsection (B) owns real property that the Department shall count under this Section, and the person is making a good faith effort to dispose of the property, the Department shall count the resource subject to the following condition:
   a. The person shall sign an agreement to:
      i. Dispose of the property, and

ii. Repay the Department as provided in A.A.C. R6-12-403(A)(7).

b. The Department shall exclude the equity value of the property for a period of 6 months beginning with the date of the signed agreement under subsection (E)(9)(a).

c. If the property is sold by the end of the 6-month period, the Department shall include any amount remaining after the Department is reimbursed as provided in A.A.C. R6-12-403(A)(7).

d. If the property is not sold by the end of the 6-month period, the Department shall include the equity value of the property.

10. Funds set aside in an Individual Development Account defined in A.A.C. R6-12-404; and
11. Any other resource specifically excluded by federal law.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1427. Determining Resource Eligibility

A. General. The Department shall follow the provisions of this Section to determine whether the person's countable resources exceed the resource standard in subsection (B).

B. Resource standard. The total equity value of all included resources shall not exceed $2000 per assistance unit.

C. Resource eligibility for coverage groups listed in R9-22-1406.

1. For the 1931 coverage group listed in R9-22-1406(B), the Department shall:
   a. Calculate the equity value of each countable resource of the assistance unit defined in R9-22-1419(B). If more than 1 owner is a member of the assistance unit, the equity value of the resource is counted only once;
   b. Add together the amounts in subsection (C)(1)(a);
   c. Compare the total amount calculated in subsection (C)(1)(b) to the resource standard provided in subsection (B); and
   d. Establish the assistance unit to be resource-eligible if the total of subsection (C)(1)(c) does not exceed the resource standard provided in subsection (B).
2. For coverage groups listed in R9-22-1406(G) and (H), the Department shall apply the following method to determine if the assistance unit is resource-eligible:
   a. Identify persons to be included in each assistance unit as specified in R9-22-1430(E)(2);
   b. Divide equally the equity value of each resource to be counted among the owners in the household;
   c. Divide equally each owner's share of the equity value of the countable resources by the number of persons for whom the owner is financially responsible applying the method under R9-22-1430(E)(2)(c);
   d. Add together the person's total allocated share of own resources and those of the financially responsible persons who are included in the assistance unit to determine the total amount of the person's resources;
   e. Determine the per-person share of the resource standard listed in subsection (B). The Department determines the per-person share of the $2000 resource standard by dividing the standard by the total number of persons in the applicant's assistance unit; and
   f. Compare the person's total income in subsection (C)(2)(d) to the per-person share of the standard as established in subsection (C)(2)(e). If the total does not exceed the person's standard, the applicant is resource-eligible.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1428. Income

A. Evaluation of income. In determining eligibility, the Department shall evaluate all income under the provisions of this Section.

B. Types of income. The Department shall include the following:

1. Gross earned income, including in-kind income, before any deductions;
2. For self-employed applicants, the gross business receipts minus business expenses; and
3. Unearned income.

C. Persons whose income is counted. The Department shall include the income of the following persons:

1. Members of the assistance unit as defined in R9-22-1419;
2. The spouse of a nonparent caretaker relative if the nonparent caretaker relative is included in the assistance unit;
3. The sponsor and sponsor's spouse of a person who is a qualified alien under A.R.S. § 36-2903.03; and
4. For the coverage group listed in R9-22-1406(B):
   a. A spouse of a parent of a dependent child if the spouse is in the home but not in the assistance unit as provided in 45 CFR 233.20(a)(3)(xiv), and
   b. A parent of a minor parent if the parent is living with the minor parent but is not included in the assistance unit, as provided in 45 CFR 233.20(a)(3)(xviii).

D. Income exclusions. For the purposes of determining eligibility for this Article, the Department shall exclude the following income:

1. Agent Orange payments;
2. AmeriCorps Network Program income under subsection (D)(4);
3. Burial benefits dispersed solely for burial expenses;
4. Cash contributions from other agencies or organizations so long as the contributions are not intended to cover the following items:
   a. Food;
   b. Shelter, including only rent or mortgage payments;
   c. Utilities;
   d. Household supplies, including bedding, towels, laundry, cleaning, and paper supplies;
   e. Public transportation fares for personal use;
   f. Basic clothing or diapers; or
   g. Personal care and hygiene items, such as soap, toothpaste, shaving cream, and deodorant;
5. Disaster assistance provided by the Federal Disaster Relief Act, disaster assistance organizations, or comparable assistance provided by state or local governments;
6. Educational grants or scholarships;
7. Energy assistance which is provided:
   a. Either in cash or in-kind by a government agency or municipal utility, or
   b. In-kind by a private nonprofit organization;
8. Earnings from high school on-the-job training programs;
9. Earned income of dependent children who are students enrolled and attending school at least half-time as defined by the institution;
10. Food stamp benefits;
11. Foster care maintenance payments intended for children who are not included in the assistance unit;
12. Funds set aside in an Individual Development Account as provided in R6-12-404;

13. Governmental rent and housing subsidies;
14. Income tax refunds, including any earned income tax credit;
15. Loans from a private applicant, a commercial, or educational institution;
16. Nonrecurring cash gifts which do not exceed $30 per applicant in any calendar quarter;
17. Radiation exposure compensation payments;
18. Reimbursement for work-related expenses which do not exceed the actual expense amount;
19. Reimbursement for JOBS Program training-related expenses;
20. Reparation and restitution payments under Section 1902(r) of the Social Security Act;
21. TANF or SSI cash assistance payment;
22. Vendor payment to a 3rd-party vendor to cover assistance unit expenses, provided the payment is made by an organization or a person who is not a member of the assistance unit;
23. Volunteers in Service to America (VISTA) income which does not exceed the state or federal minimum wage;
24. Vocational rehabilitation program payments made as reimbursement for training-related expenses, subsistence and maintenance allowances, and incentive payments which are not intended as wages;
25. Women, Infants, and Children (WIC) benefits; and
26. Any other income specifically excluded by applicable federal law.

E. Special income provision for child support. The Department shall:
1. Consider child support to be the income of the child for whom the support is intended; and
2. Count the child support income after deducting $50 per child if the child receives support:
   a. Directly from the absent parent,
   b. Through the Clerk of the Court, or
   c. Through the Court but assigned to DCSE.

F. Special income provision for nonrecurring lump sum income. The Department shall count a lump-sum payment as income in the month received.

G. Methods to determine projected monthly income.
1. The Department shall average income if income is received irregularly or regularly but from sources or in amounts which vary as follows:
   a. Add together income from a representative number of weeks or months, and
   b. Divide the resulting sum by the same number of weeks or months to determine the monthly amount.
2. The Department shall prorate income if income received is intended to cover a fixed period of time. The income received shall be averaged over the period of time the income is intended to cover to determine a monthly prorated amount.
3. The Department shall evaluate income under a fixed-term employment contract as follows:
   a. If contract income is received on a monthly or more frequent basis throughout all months of the contract, count the income in the month received;
   b. If contract income is received before or during the time the work is performed, but not as specified in subsection (3)(a), prorate the income over the number of months in the contract; or
   c. If payment is received only upon completion of the work:
      i. Divide the amount of the contract-payment by the number of months in the contract,
      ii. Apply the appropriate earned-income disregards specified in R9-22-1429 to determine net income for each month in the contract period,
      iii. Add together the net amount determined for each month in subsection (G)(3)(c)(ii) to determine total amount to count for the contract period, and
      iv. Count the total amount determined in subsection (G)(3)(c)(iii) as unearned lump-sum income under subsection (F).
4. The Department shall use the actual amount of income received in a month if the person:
   a. Receives or expects to receive less than a full month's income from a new source,
   b. Loses a source of income, or
   c. Is paid daily.
5. The Department shall use actual income received for a month in determining eligibility for prior quarter coverage as specified in R9-22-1432; or
6. The Department shall use the striker's prestrike monthly income if a person whose income shall be included is on strike.

H. Determining monthly income.
1. The Department shall calculate monthly income using the method described in subsection (G) for each assistance unit.
2. The projected income discussed in subsection (G) includes income which the assistance unit receives and expects to receive in a benefit month and shall be based on the Department's assessment of the assistance unit's current, past, and future circumstances.
3. The Department's calculation shall include all gross income from every source available to the assistance unit, except those excluded in subsection (D).
4. The Department shall convert income received more frequently than monthly into a monthly amount as follows:
   a. Multiply weekly amounts by 4.3,
   b. Multiply bi-weekly amounts by 2.15,
   c. Multiply semi-monthly amounts by 2.
5. The Department shall determine a new calculation of projected income:
   a. At each review, and
   b. If there is a change in countable income.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1429. Earned Income Disregards

A. General. Except as provided in subsections (B)(2) and (C), the Department shall apply the earned income disregards in this Section to each employed person's gross earnings.

B. Disregards. The Department shall apply the method in this subsection to calculate the amount of the earned income:
1. Subtract a $90 cost of employment (COE) allowance from the gross amount of earned income;
2. For coverage groups listed in R9-22-1406(B), R9-22-1406(G), and R9-22-1406(H), subtract either 30% of the remaining income or $30 plus 33% of the remaining income after applying the $90 COE as follows:
   a. Disregard 30% of the earned income for any month the person is employed; or
   b. If the 30% disregard results in income ineligibility of the assistance unit, the Department shall apply the $30 plus 33% income disregard for a period not to exceed 4 consecutive months beginning with the 1st month of employment; and

c. The $30 plus 33% earned income disregard shall not apply again until after 12 months of ineligibility have elapsed; and

3. Subtract an amount billed by the child care provider for the care of each dependent child or incapacitated adult member of the assistance unit, not to exceed:
   a. For a wage-earner employed full-time (86 hours a month):
      i. $200 for a child under age 2, and
      ii. $175 for the other dependents specified in subsection (B)(3); and
   b. For a wage-earner employed part-time (less than 86 hours a month):
      i. $100 for a child under age 2, and
      ii. $88 for the other dependents specified in subsection (B)(3).

C. Loss of disregards. The Department shall not apply the earned income disregards listed in subsections (B)(2), (B)(3), and (B)(4) if the person:
1. Terminates or reduces employment within 30 days preceding a benefit month unless good cause is established as specified in R6-10-119(A); or
2. Fails to report to the Department a change in income within 10 days from the date the change becomes known. The change report to the Department shall be postmarked no later than the 10th day from the date the change becomes known. Good cause for failure to timely report a change or verification is limited to sickness, accident, or other family hardship.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1430. Determining Income Eligibility

A. General. The Department shall evaluate income eligibility under this Section for any applicable eligibility coverage group listed in R9-22-1406.

B. Income eligibility standard.
1. For the coverage groups listed in R9-22-1406(B), R9-22-1406(G), and R9-22-1406(H), the income eligibility standard is 36% of the need standard specified in subsection (C) for the number of persons in the assistance unit.
2. For the coverage groups listed in R9-22-1406(I) and R9-22-1406(J), the income eligibility standard is the percentage of the FPL as follows:
   a. 140% of the FPL for a pregnant woman or a child under the age of 1,
   b. 133% of the FPL for a child age 1 through 5, and
   c. 100% of the FPL for a child born on or after 10/1/83 who is age 6 and over.
3. For the coverage group listed in R9-22-1406(F), the standard is 185% of the FPL for the number of persons in the assistance unit.

C. Need standard. The need standard is 100% of the 1992 FPL, adjusted for a shelter cost factor as provided in subsections (C)(1) and (C)(2) for the number of persons in the assistance unit. The shelter cost factor reduces the federal poverty level by 37% if the person does not pay, or is not obligated to pay, shelter costs for the place of residence.
1. The Department shall use 100% of the need standard if:
   a. The assistance unit pays, or is obligated to pay, all or part of the shelter costs for the place in which assistance unit members reside. Shelter costs include rent, mortgage, or taxes;
   b. The assistance unit members reside in subsidized public housing;
   c. A member of the assistance unit works in exchange for rent; or
   d. A nonparent relative whom the Department excludes from the assistance grant:
      i. Charges the dependent child rent, or
      ii. Uses a portion of the dependent child's cash assistance grant to pay household expenses.
2. If the assistance unit does not meet the requirements of subsection (C)(1), the Department shall determine the assistance unit's need standard based on 63% of the 1992 100% FPL.

D. Determining income eligibility.
1. The Department shall find the assistance unit income-eligible if the assistance unit's income meets the appropriate income standard specified in subsection (B).
2. The Department shall establish income eligibility as follows:
   a. Identify the assistance unit under R9-22-1419 for the appropriate coverage group.
   b. Determine whose income is to be counted under R9-22-1428(C).
   c. Determine what income is to be counted under R9-22-1428.
   d. Determine the amount of income to be counted under subsection (E)(2), R9-22-1428, and R9-22-1429.
   e. Compare the amount in subsection (D)(2)(d) to the appropriate income standard in subsection (B).
   f. Determine the assistance unit income eligibility if the income does not exceed the appropriate income standard specified in subsection (B).

E. Method to determine income eligibility. The Department shall apply the following method to establish the requirements of (D)(2)(d), (e), and (f):
1. For coverage group listed in R9-22-1406(B), the Department shall determine whether the assistance unit in R9-22-1419(B) meets the following 3 income tests:
   a. To determine whether the assistance unit meets 185% of the need standard defined in subsection (C), the Department shall:
      i. Determine the assistance unit's gross income specified in subsection (D)(2).
      ii. Deduct the income disregards described in subsection (E)(1)(d).
      iii. Compare the resulting amount of income to the 185% standard. If the amount does not exceed the standard, the assistance unit meets this test.
   b. If the assistance unit meets the 185% test under subsection (E)(1)(a), the Department shall determine whether the assistance unit meets the need test defined in subsection (C) as follows:
      i. Use the same amount of gross income in subsection (E)(1)(a)(i);
      ii. Deduct the income disregards described in subsection (E)(1)(d) and in R9-22-1429;
      iii. Compare the resulting amount of income to the need standard in subsection (C). If the amount is less than the standard, the assistance unit meets this test.
   c. If the assistance unit meets the need test in subsection (E)(1)(b), the Department shall compare the amount of income in subsection (E)(1)(b)(iii) to the payment standard in subsection (B)(1). If the amount is less than the standard, the assistance unit qualifies and is income-eligible.

d. For the purpose of subsections (E)(1)(a) and (E)(1)(b), the Department shall disregard the following income of children who are members of the assistance unit defined in R9-22-1419:
   i. All earned income from participation in the JTPA for up to 6 months per calendar year; and
   ii. All unearned income received from participation in JTPA.

2. For coverage groups listed in R9-22-1406(G), R9-22-1406(H), R9-22-1406(I), and R9-22-1406(J), the Department shall determine income eligibility separately for each applicant as follows:
   a. Establish a separate assistance unit for each applicant as provided in R9-22-1419(E);
   b. After applying all applicable income disregards, divide equally the income of financially responsible relatives specified in subsection (E)(2)(c) among the owner of the income and other persons in the household for whom the owner is financially responsible. The resulting amount is the person's allocated income.
   c. The following persons are financially responsible:
      i. A child is financially responsible for the child,
      ii. A parent is financially responsible for the parent and the parent's dependent children, and
      iii. A married person is financially responsible for the person and the person's spouse.
   d. Determine the per-person share of the appropriate income standard as provided in subsection (B). The Department shall determine the per-person share of the income standard by dividing the income standard by the total number of persons in the applicant's assistance unit. For example:
      i. A child and the child's parent is a household of 2. The child's share of the appropriate income standard is 1/2 of 2.
      ii. A pregnant minor child, the unborn child, the minor child's 2 parents and the minor child's spouse is a household of 5. The pregnant minor child's share of the appropriate income standard is 2/5. The Department shall count the unborn child of the pregnant minor child in determining the pregnant minor child's per-person share of the income standard.
   e. Add together the applicant's share of the applicant's own income with any income allocated to the applicant under subsection (E)(2)(b), and compare the applicant's total income to the per-person share of the standard under subsection (E)(2)(d). If the applicant's income is equal to or less than the income standard under (E)(2)(d), the applicant qualifies and is income eligible:

3. Income eligibility or coverage groups listed in R9-22-1406(F) shall be calculated as follows:
   a. Divide the total gross earned income for the preceding 6-month period of TMA by 6 to determine average gross earned income for the period;
   b. Subtract the monthly child care amount billed by the child care provider from the average gross earned income. To be allowed as a disregard under R9-22-1429(D), the child care shall be necessary for the employment of the caretaker relative.;
   c. The resulting total may not exceed 185% of FPL.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1431. Effective Date of Eligibility
Except as provided in R9-22-1432 and R9-22-1433, the effective date of eligibility shall be the 1st day of the month of application if the applicant is eligible that month, or the 1st eligible month following the application month.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1432. Prior Quarter Eligibility
A. The Department shall evaluate the applicant's eligibility for 1 or more months during the 3-month period before the 1st day of the month of application if the applicant:
   1. Received a medical service at any time during the 3-month period prior to the application month; and
   2. Would have been eligible under this Article, if the applicant had filed an application at the time of receiving services.

B. The Department shall determine the applicant's eligibility under any eligibility coverage group listed in R9-22-1406(A), R9-22-1406(G), R9-22-1406(H), R9-22-1406(I), or R9-22-1406(J) for 1, 2, or all 3 of the months before the 1st day of the month of application.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1433. Deemed Newborn Eligibility
A child born to a categorically eligible mother is automatically eligible for AHCCCS medical assistance for a period not to exceed 12 months beginning with the child's date of birth and ending with the last day of the month in which the child turns age 1, if the child continuously lives with the mother in the state of Arizona.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1434. Extended Medical Assistance Coverage for A Pregnant Woman
A. Except as provided in subsection (C), a pregnant woman who applies for and is determined categorically eligible for medical assistance during the pregnancy, remains eligible throughout the 60-day postpartum period.
B. The postpartum period begins the day the pregnancy terminates and ends the last day of the month in which the 60th day falls.
C. Postpartum coverage will not be provided if the woman:
   1. Voluntarily withdraws from the Medical Assistance program,
   2. Moves out-of-state, or
   3. Is incarcerated.

D. Extended coverage under this Section applies only if the person does not receive medical assistance under another categorical coverage group provided in 9 A.A.C. 22 or 9 A.A.C. 28.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1435. Family Planning Services Extension Program
A. Except as specified in this Section, a person may receive family planning services as provided in A.R.S. § 36-2907.04.
B. The Administration shall deny or terminate family planning services under this Section if any 1 of the following occurs:
   1. Voluntary withdrawal,
   2. Loss of contact,
   3. Failure to cooperate,

4. Failure to provide information,
5. Incarceration,
6. Move out-of-state,
7. Sterility, or
8. Death.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1436. Eligibility Appeals

A. Adverse actions. A person may appeal and request a hearing concerning any of the following adverse actions:
1. Complete or partial denial of eligibility;
2. Suspension, termination, or reduction of medical assistance; or
3. Delay in the eligibility determination beyond 45 days from the application date.

B. Notice of Action. The Department shall personally deliver or mail, by regular mail, a Notice of Action to the person affected by the action. For the purpose of this Section, the date of the Notice of Action shall be the date of personal delivery to the applicant or the postmark date, if mailed.

C. Automatic adjustments. Applicants and recipients are not entitled to a hearing to challenge changes made automatically as a result of changes in federal or state law, unless the Department has incorrectly applied the law to the person seeking the hearing.

D. Hearings to the Department of Economic Security. Applicants and recipients may request a hearing from the Department. The Department shall conduct the hearing in accordance with the Department's appeal procedures contained in A.A.C. R6-12-1002, R6-12-1003, and R6-12-1005 through R6-12-1015. For purposes of this Section, any references in the Department's rules to the word "benefits" shall refer to medical assistance, any reference to the cash assistance program shall refer to the medical assistance program, and references to overpayments are not applicable.

E. Stay of adverse action pending appeal and exceptions.
1. If an appellant files a request for appeal within 10 calendar days after the date of the Notice of Action, the Department shall not impose the adverse action and shall continue medical assistance at the current level unless:
   a. The appellant specifically waives continuation of current benefits, or
   b. The appeal results from a change in federal or state law which mandates an automatic adjustment for all classes of recipients and does not involve a misapplication of the law;
2. The Department shall not impose the adverse action until receipt of an official written decision from the hearing officer except in the following circumstances:
   a. At the hearing and on the record, the hearing officer finds that:
      i. The sole issue involves application of law,
      ii. The Department properly applied the law, and
      iii. The Department determined the correct level of assistance for the appellant;
   b. A change in eligibility occurs for a reason other than the issue on appeal, and the assistance unit receives and fails to timely appeal a Notice of Action concerning the change;
   c. Federal or state law mandates an automatic adjustment for classes of recipients;
   d. The appellant withdraws the request for hearing; or
   e. The appellant fails to appear for a scheduled hearing without prior notice to the Department's Office of Appeals, and the hearing officer does not rule in favor of the appellant based upon the record.
3. An appellant whose medical assistance has been continued may be financially liable for all medical assistance received during a period of ineligibility if the Department upholds a discontinuance decision.
4. If the appellant files a request for appeal more than 10 days after, but within 20 days of, the date of the Notice of Action, the Department may impose the adverse action while the appeal is pending.

F. Retroactive eligibility. If the Department's Office of Appeals hearing decision upholds the appellant, the decision is retroactive to the effective date contained in the Notice of Action.

G. Appeal to Appeals Board.
1. An appellant may appeal the hearing decision to the Department's Appeals Board under A.A.C. R6-12-1014.
2. The Appeals Board shall issue a final written decision to the appellant under A.A.C. R6-12-1015. The Appeals Board's final decision shall identify the appellant's right to appeal to the Administration.

H. Review of the Appeals Board decision.
1. The appellant may request a review of the Appeals Board's final decision by filing an appeal with the Administration under Article 8 within 15 days of the postmark date of the Appeals Board's decision.
2. Unless the appellant requests a de novo hearing, the appeal to the Administration shall consist of a review of the record of the Department's evidentiary hearing to determine whether substantial evidence in the record supports the decision. In the event the appellant requests a de novo hearing, the Administration shall conduct the hearing under Article 8.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

ARTICLE 15. SSI MAO ELIGIBILITY

R9-22-1501. SSI Medical Assistance Only (MAO) Coverage Groups

A. Using the eligibility criteria and requirements in this Article, the Administration shall determine eligibility for services described in Articles 2 and 12, for applicants in the following eligibility groups:
1. A SSI noncash person who is aged, blind, or disabled, under 42 CFR 435.210, August 18, 1994, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
2. A disabled child (DC), under 42 U.S.C. 1396a(a)(10)(A)(i)(II), July 1, 1997, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments. A disabled child is a child who:
   a. Was receiving SSI cash benefits as a disabled child on August 22, 1996;
   b. Lost SSI cash benefits effective July 1, 1997, or later, due to a disability determination under Section 211(d)(2)(B) of Subtitle B of P.L. 104-193, July 1, 1997, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments; and
   c. Continues to meet the disability requirements for a child which were in effect on August 21, 1996.

3. A disabled adult child (DAC), as specified in 42 U.S.C. 1383c(c), who:
   a. Was determined disabled by the Social Security Administration before attaining the age of 22 years,
   b. Became entitled to or received an increase in child's insurance benefits under Title II of the Social Security Act on the basis of blindness or disability,
   c. Was terminated from SSI cash benefits due to entitlement to or an increase in Title II of the Social Security Act (DAC) income,
   d. Has income equal to or below 100% of the FBR if the Title II (DAC) income is excluded from the calculation of eligibility, and
   e. Is 18 years of age or older.
4. A disabled widow or widower (DWW), as specified in 42 U.S.C. 1383c(d) who:
   a. Is blind or disabled,
   b. Is ineligible for Medicare Part A benefits,
   c. Received SSI cash benefits the month before Title II of the Social Security Act (DWW) benefit payments began,
   d. Would have income equal to or below 100% of the FBR since losing the SSI cash benefits if the amount of the Title II of the Social Security Act benefit (DWW) income was excluded from the calculation of eligibility, and
   e. Would continually meet all conditions of eligibility specified in this Article after losing SSI cash benefits.
5. A person, as specified in 42 CFR 435.135 who:
   a. Is aged, blind, or disabled;
   b. Receives benefits under Title II of the Social Security Act;
   c. Received SSI cash benefits in the past;
   d. Received SSI cash benefits and Title II of the Social Security Act benefits concurrently for at least 1 month anytime after April 1977;
   e. Became ineligible for SSI cash benefits while receiving SSI and Title II of the Social Security Act concurrently; and
   f. Would have income equal to or below 100% of the FBR if the Title II of the Social Security Act COLA increases received on or after losing SSI Cash benefits were excluded from the calculation of eligibility.
6. A state funded nonqualified alien, as specified in A.R.S. § 36-2903.03.C who:
   a. Is aged, blind, or disabled;
   b. Received SSI cash or AHCCCS medical benefits under an SSI MAO coverage group listed in subsections (A)(1) through (A)(5) on or before August 21, 1996**;** and
   c. Was residing in the United States under color of law on or before August 21, 1996.

B. Under the Federal Emergency Services Program (FESP), a person who meets the conditions of eligibility for SSI noncash in subsection (A)(1), but who does not meet the alien status requirements specified in R9-22-1504(A) or (B), shall be entitled to services described at R9-22-217.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1502. Eligibility Determination Process

A. Applications for SSI MAO.
1. The Administration shall provide a person the opportunity to apply for SSI MAO.
2. An applicant may be accompanied, assisted, or represented by another person in the application process.
3. To apply for SSI MAO, a person shall submit a written application to the Administration's eligibility office.
   a. The application shall contain an applicant's name and address.
   b. The application may be submitted by the applicant or representative.
   c. The Part I Application shall be signed by an applicant requesting SSI MAO benefits or by a representative.
   d. An application shall be witnessed and signed by a 3rd-party if an applicant signs an application with a mark.
   e. The application date is the date an application is received at any Administration office.
4. Except when there is an emergency beyond the Administration's control, the Administration shall not delay the eligibility determination beyond the following timeframes when information necessary to make the determination has been provided or obtained:
   a. 90 days for an applicant applying on the basis of disability; or
   b. 45 days for all other applicants.
5. The applicant or representative who filed an application may withdraw the application, either orally or in writing, at the office where the applicant or representative filed the application. An applicant who withdraws an application shall receive a denial notice under subsection (I).

B. Determination of eligibility for an applicant terminated from SSI cash program.
1. Continuation of AHCCCS medical assistance. The Administration shall continue AHCCCS medical assistance for an applicant terminated from SSI cash program until a redetermination of eligibility under subsection (B)(2) is completed under 42 CFR 435.916.
2. Coverage group screening. The Administration shall screen for eligibility under any coverage group specified in A.R.S. §§ 36-2901.4(b) and 36-2934.
   a. If an applicant has filed an application for ALTCS coverage, the Administration shall determine eligibility under 9 A.A.C. 28, Article 4.
   b. If an applicant is aged, blind, or disabled, but not in need of long-term care services, the Administration shall determine eligibility under this Article.
   c. If an applicant is a child, is pregnant, or the caretaker relative of a deprived child, the Administration shall refer the case to DES for an eligibility decision under Article 14.
3. Eligibility decision.
   a. If the applicant is eligible, the Administration shall send a notice informing the applicant that AHCCCS medical assistance will continue.
   b. If the applicant is ineligible, the Administration shall send a notice proposing discontinuing AHCCCS medical coverage.
4. County referral. If an applicant is found ineligible under subsection (B)(2), the Administration shall refer the person to a county AHCCCS eligibility office to apply for medical assistance under Article 16. The referral shall include:
   a. Referral instructions on the notice of proposed termination of categorical eligibility;
   b. Information about the county AHCCCS eligibility determination process, including location of county eligibility offices, income and resource limits, other

conditions of eligibility, and verification requirements; and

c. A postcard, which if completed and returned to the county eligibility office under R9-22-1604, shall initiate an MI/MN application.

C. Conditions of SSI MAO Eligibility. An applicant shall only be approved for SSI MAO under this Article when the following conditions of eligibility are met:

1. Coverage group under R9-22-1501;
2. State residency under R9-22-1503;
3. Citizenship and alien status under R9-22-1504;
4. SSN under R9-22-1505;
5. Resources under R9-22-1506;
6. Income under R9-22-1507;
7. A legally authorized person shall assign rights to the Administration for medical support and for payment of medical care from any 1st-and 3rd-parties and shall cooperate by:
   a. Establishing paternity and obtaining medical support and payments unless an applicant establishes good cause for not cooperating, and
   b. Identifying and providing information to assist the Administration in pursuing 1st-and 3rd-parties who may be liable to pay for care and services unless an applicant establishes good cause for not cooperating; and
8. Application for potential benefits by requiring an applicant to take all necessary steps to obtain annuity, pension, retirement, and disability benefits for which an applicant may be entitled, unless the person establishes good cause for not doing so.

D. Inmate of a public institution. An inmate of a public institution is not eligible for SSI MAO if federal financial participation (FFP) is not available.

E. Verification. If requested by the Administration, a person shall provide information and documentation to verify the following or authorize the Administration to obtain verification of the following:

1. Coverage groups as specified in R9-22-1501,
2. State residency as specified in R9-22-1503,
3. Citizenship and alien status as specified in R9-22-1504,
4. SSN as specified in R9-22-1505,
5. Resources as specified in R9-22-1506,
6. Income as specified in R9-22-1507,
7. 1st-and 3rd-party liability and recovery as specified in subsection (C)(7),
8. Applying for potential benefits as specified in subsection (C)(8), and
9. Other individual circumstances necessary to determine an applicant's eligibility.

F. Documentation of the eligibility decision. The SSI MAO eligibility interviewer shall include information in a person's case record to support any decision on a person's application.

G. Eligibility effective date. Eligibility shall be effective the 1st day of the month all eligibility requirements are met, but no earlier than the prior quarter period.

H. Prior quarter.

1. Prior quarter period. Eligibility for the prior quarter shall be no earlier than 3 months prior to the month of application.
2. Prior quarter eligibility.
   a. Eligibility for prior quarter acute care coverage is determined for each month of a prior quarter period on a month-by-month basis and shall be for 1, 2, or 3 months of the prior quarter period.
   b. A person shall meet all eligibility criteria related to a coverage group listed in R9-22-1501 for each approved prior quarter month.

I. Notice. The Administration shall send the person a written notice of the decision regarding the application. This notice shall include a statement of the intended action, explanation of a person's hearing rights as specified in Article 8, and:

1. If approved, the notice shall contain:
   a. The effective date of eligibility; and
   b. If approved under FESP, the emergency services certification end date.
2. If denied, the notice shall contain:
   a. The effective date of the denial;
   b. A statement detailing the reason for the denial, including specific financial calculations and the financial eligibility standard if applicable; and
   c. The legal authority supporting the decision.

J. Confidentiality. The agency shall maintain the confidentiality of the person's records and shall not disclose the person's financial, medical, or other privacy interests except as specified in R9-22-512.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1503. State Residency

As a condition of eligibility, a person shall be a resident of Arizona under 42 CFR 435.403, December 21, 1990, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1504. Citizenship and Qualified Alien Status

A. Requirements for coverage groups listed in R9-22-1501(A)(1) through (A)(5). As a condition of eligibility, an applicant applying for or a person receiving assistance shall be either:

1. A citizen of the United States under A.R.S. § 36-2903.03; or
2. A qualified alien as specified in 8 U.S.C. 1641 and A.R.S. § 36-2903.03, to the extent that A.R.S. § 36-2903.03 is consistent with federal law.

B. Requirement for the coverage group listed in R9-22-1501(A)(6). As a condition of eligibility, an applicant applying for or a person receiving assistance shall be:

1. A nonqualified alien who received AHCCCS benefits under SSI cash or SSI MAO, except for FESP, on August 21, 1996; and
2. A person who was residing in the United States under color of law on or before August 21, 1996, as specified in A.R.S. § 36-2903.03. Coverage under this program is subject to the appropriation of funds by the Arizona Legislature.

C. FESP. The Administration shall determine an applicant's eligibility under FESP if the applicant does not meet the citizenship or qualified alien status requirements in subsections (A) and (B).

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1505. Social Security Enumeration

A. Requirement for the coverage groups listed in R9-22-1501(A)(1) through (A)(5). As a condition of eligibility an

applicant shall furnish a SSN, as specified in 42 CFR 435.910 and 435.920.

B. Exception for coverage under R9-22-1501(B). An undocumented person who is applying for or receiving assistance is not required to apply for or furnish a SSN.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1506. Resource Criteria for SSI MAO Eligibility

A. Resource eligibility. Except as provided in subsection (B), resource eligibility is determined using the resource criteria in 42 U.S.C. 1382(a)(2)(B), August 5, 1997, incorporated by reference and on file with the Administration and the Secretary of State. The incorporation by reference contains no future editions or amendments.

B. Exceptions. The value of the following resources is excluded from eligibility determination:
1. Household goods and personal effects;
2. Burial Insurance;
3. Assets that an applicant has irrevocably assigned to fund the expenses of a burial;
4. The value of life insurance if the face value does not exceed $1,500 total per insured applicant and the policy has not been assigned to fund a burial plan or declaratively designated as a burial fund;
5. The equity value up to $1,500 of an asset to be used as a burial fund or a revocable burial arrangement if there is no irrevocable burial arrangement, and if an applicant remains continuously eligible, all appreciation in the value of such assets; and
6. The value of oil, mineral, and timber rights.

C. Resource limits. A person is not eligible if countable resources owned by the person exceed $2,000 for a person or $3,000 for a couple under 42 U.S.C. 1382(a)(3)(A) and (B).

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1507. Income Criteria for Eligibility

A. Countable income for a person is determined as follows:
1. General income eligibility. Except as specified in subsections (A)(2) and (3), income eligibility is determined using the methodology in 42 U.S.C. 1382(a), August 5, 1997, and 42 U.S.C. 1382a, August 22, 1996, incorporated by reference and on file with the Administration and the Secretary of State. These incorporations by reference contain no future editions or amendments.
2. Exceptions which apply to all coverage groups.
   a. In-kind support and maintenance is excluded. In-kind support and maintenance is explained at 42 U.S.C. 1382a(a)(2)(A), August 22, 1996, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
   b. For a person living with a spouse, the computation rules for an eligible couple are followed for the net income calculation, even if the spouse is not eligible for or applying for SSI or SSI MAO.
   c. In determining the net income of a couple living with a child, a child allocation is allowed as a deduction from the combined net income of the couple for each child regardless of whether the child is ineligible or eligible. For the purposes of this Section, a child means a person who is unmarried, natural or adopted, under age 18 or under age 22 if a full-time student. Each child's allocation deduction is reduced by that child's income, including public income maintenance payments**,** using the methodology described in 20 CFR 416.1163(b)(1) and (2), May 4, 1989, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
   d. In determining net income of a person who is not living with a spouse but living with a child, a deduction from the parent's net income using the methodology described in 20 CFR 416.1163(b)(1) and (2), is allowed for each child regardless of whether the child is ineligible or eligible. Each child's allocation deduction is reduced by that child's income, including public income maintenance payments.
   e. In determining the income deemed available to an applicant who is a child, from an ineligible parent or parents, an allocation for each eligible or ineligible child of the parent is allowed as a deduction from the parent's income using the methodology described in 20 CFR 416.1165(b) and each child's allocation is reduced by that child's income, including public income maintenance payments. The methodology in 20 CFR 416.1165(b), January 8, 1997, is incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
3. Exceptions which apply to specific coverage groups.
   a. For a person in the DAC coverage group, defined by R9-22-1501(A)(3), the applicant's Title II of the Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(c), March 29, 1996, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
   b. For a person in the DWW coverage group, defined by R9-22-1501(A)(4), the applicant's Title II of the Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(b) and (d), March 29, 1996, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
   c. For an applicant in the coverage group defined by R9-22-1501(A)(5), the portion of the applicant's Title II of the Social Security Act benefits attributed to cost-of-living adjustments received by the applicant since the effective date of SSI ineligibility is disregarded in determining income eligibility under 42 CFR 435.135, May 12, 1986, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. As a condition of eligibility for all coverage groups, countable income shall be equal to or less than 100% of the SSI FBR, adjusted annually, for a person or a married couple.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1508. Changes and Redeterminations

A. Reporting and verifying changes.

1. Under 42 CFR 435.916, a member shall report to the SSI MAO unit the following changes for a member, a member's spouse, and a member's dependent children:
   a. A change of address;
   b. An admission to a penal institution;
   c. A change in the household's members;
   d. A change in income;
   e. A change in resources;
   f. A determination of eligibility for other benefits;
   g. A death of any household member;
   h. A change in marital status;
   i. A change in school attendance;
   j. A change in Arizona state residency;
   k. A change in U.S. citizenship or alien status;
   l. Receipt of a SSN under R9-22-1505;
   m. A change in trust assets, income, and disbursements;
   n. A change in 1st-or 3rd-party liability which may contribute to the payment of all or a portion of the person's medical costs; and
   o. Any other change that may affect the applicant's eligibility.
2. A person may report a change either orally or in writing and shall include the:
   a. Name of the affected applicant;
   b. Change;
   c. Date the change occurred;
   d. Name of the person reporting the change; and
   e. Social Security or case number of the household member, if known.
3. A person shall provide verification of changes upon request of AHCCCS.
4. A person shall report anticipated changes in eligibility as soon as the future event becomes known.
5. A person shall report unanticipated events within 10 days of the date the change occurred.

B. Processing of changes and redeterminations. If a person receives benefits under R9-22-1501(A), a person's eligibility shall be redetermined at least once every 12 months or more frequently when changes occur, under 42 CFR 435.916.

C. Actions that may result from a redetermination or change. The processing of a redetermination or change shall result in 1 of the following findings:
1. No change in eligibility,
2. Discontinuance of eligibility if any condition of eligibility is no longer met,
3. Suspension of eligibility if any condition of eligibility is temporarily not met, or
4. A change in the program under which a person receives assistance.

D. Notices.
1. Contents of notice. The Administration shall issue a notice whenever it takes an action regarding a person's eligibility. A notice shall contain the following information:
   a. A statement of the action that is being taken;
   b. The effective date of the action;
   c. The reason for the intended action;
   d. The actual amounts used in the eligibility determination and specify the amount by which a person exceeded standards if eligibility is being discontinued because either a person's resources exceed the resource limit described at R9-22-1506 or the person's income exceeds the income limit described at R9-22-1507;
   e. The specific law or rule that supports the action proposed by the Administration, or a change in federal or state law that requires an action;
   f. An explanation of an applicant's right to request a fair hearing; and
   g. If a discontinuance or suspension, an explanation of the date by which a fair hearing shall be requested so that eligibility will be continued.
2. Advance notice of changes in eligibility. Advance notice means a proposed notice of action that is issued to the person at least 10 days before the effective date of the proposed action under 42 CFR 435.919. Except as specified in subsection (D)(3), advance notice shall be issued whenever adverse action is taken to discontinue or suspend eligibility if an eligible applicant no longer meets a condition of eligibility.
3. Exceptions from advance notice. Under 42 CFR 431.213, notice shall be issued to the person to discontinue eligibility no later than the effective date of action if:
   a. A person provides a clear written statement, signed by that person, that services are no longer wanted;
   b. A person provides information that requires termination of eligibility and a person signs a written statement waiving advance notice;
   c. A person cannot be located and mail sent to the person's last known address has been returned as undeliverable;
   d. A person has been admitted to a penal institution where a person is ineligible for benefits;
   e. A person has been approved for Medicaid in another state; or
   f. The Administration receives information confirming the death of a person.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

ARTICLE 16. STATE-ONLY ELIGIBILITY

R9-22-1601. Who May Apply for MI/MN Benefits

A. Right to apply. The county eligibility staff shall provide the unrestricted opportunity for any person to apply for MI/MN benefits.

B. Application by the head-of-household. The head-of-household shall apply on behalf of all members of the household.

C. Application by a designated representative. A designated representative may act on behalf of the head-of-household to apply for MI/MN if no household member is able to act as head-of-household.
1. The designated representative shall have all rights and responsibilities and fulfill all the requirements as specified for the head-of-household in this Article.
2. A designated representative shall be 1 of the following:
   a. A person appointed by a tribal court or through protective proceedings as defined in A.R.S. Title 14, Chapter 5, or the applicant's guardian, conservator, or executor;
   b. A representative authorized in writing by the head-of-household;
   c. Any adult household member who would have been a household member if not for categorical status;
   d. A person who has knowledge of the family circumstances if the head-of-household is deceased or cannot designate a representative due to incapacity and there is no other available designated representative as defined in this Section;

i. Incapacity shall be verified by written documentation signed by a licensed physician, physician assistant, nurse practitioner, or a registered nurse under the direction of a licensed physician.
ii. An applicant who meets the definition of designated representative under this subsection but who is incapacitated under subsection (C)(2)(d)(i) is not an available designated representative.
e. A person who applies on an applicant's behalf as permitted in subsections (E) and (F).

D. Applications by dependent children. A dependent child may be head-of-household and apply for MI/MN only coverage if the dependent child:
1. Is pregnant or is a parent residing with the dependent child's own child, and
2. Does not live with a person who is legally responsible for that child's support.

E. Applications for dependent children. Except as permitted in subsection (D), if a dependent child is a member of a household that does not include a parent or specified relative, only 1 of the following may apply for MI/MN coverage on the child's behalf:
1. The dependent child's legal guardian;
2. A representative of an authorized agency appointed through court proceedings established by A.R.S. § 8-538 et seq.; or
3. A foster parent duly appointed by:
a. The Superior Court of the state of Arizona,
b. The Department of Economic Security,
c. A Native American Tribal Court, or
d. A Native American Tribal Agency.

F. Applications by court-appointed representatives. If a court appoints a guardian, conservator, or executor for a person, the application shall be completed by the court's appointee.

G. Verification of representative's qualifications. If a designated representative or a legal representative for a dependent child applies on behalf of the head-of-household or a dependent child, the county eligibility staff shall verify that the representative meets 1 of the conditions specified in subsection (C)(2).

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1602. Application for MI/MN Benefits

A. Distribution of application forms. Any person may request an application form from the county eligibility staff either in-person, through the mail, or by telephone.
1. The county eligibility staff shall ask each person who inquires either in-person or by telephone about the AHCCCS program, the following question: "Do you want to apply for AHCCCS?"
2. If the response is yes, the county eligibility staff shall:
a. Mail the Part I Application within 3 working days of the receipt of:
i. A telephone request, or
ii. A mail request, or
b. If the request is in-person, the county eligibility staff shall immediately provide the person with a Part I Application.

B. Initiation of the application process. The head-of-household may initiate the application by submitting a completed Part I Application to a county eligibility staff within the county of the head-of-household's physical residence. A completed application shall contain the name, address, signature or mark of the applicant, and the date.

C. Acceptance of the application. The county eligibility staff shall date stamp or manually date the application. For applications that are not priority applications under R9-22-1603, the received date is the application date.

D. Confirmation of receipt. The county eligibility staff shall return a copy of the receipt and dated Part I Application to the head-of-household:
1. Immediately, for an application submitted in-person; or
2. Within 3 days of receipt of the Part I Application, for applications received by mail. The confirmation of receipt may be provided with the appointment notice under subsection (E).

E. Scheduling the interview. A county eligibility staff shall schedule a face-to-face interview with the head-of-household upon receipt of a Part I Application.
1. If the application is submitted in-person, the county eligibility staff shall either immediately conduct the interview or schedule a mutually agreeable appointment and provide the head-of-household with written confirmation of the appointment.
2. If the completed Part I Application is received by mail, the county eligibility staff shall schedule an interview, or attempt to contact the head-of-household to schedule an interview, within 3 working days. The head-of-household may change the interview appointment 1 time if the request to change is made before the originally scheduled interview. The county eligibility staff shall then change the interview to a mutually agreeable time.
3. If the county eligibility staff does not receive acknowledgment of a scheduled interview from the head-of-household, the county eligibility staff shall make at least 1 additional attempt to notify the head-of-household of the scheduled appointment.

F. Priority for a pregnant woman. The county eligibility staff shall give priority to the processing of an application for a pregnant woman.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1603. Priority Applications for MI/MN Eligibility

A. Conditions for a priority application. A provider of medical services may initiate a priority MI/MN application for a patient and the patient's household if the patient is not an AHCCCS member but is potentially MI/MN, ELIC, or SESP eligible, and
1. Is receiving medical care, or received medical care within the previous 2 days;
2. Is hospitalized; or
3. Has been hospitalized during the previous 2 days.

B. Verification of AHCCCS coverage. If a patient's AHCCCS eligibility is not known, the provider shall contact the Administration to determine whether the patient is eligible.

C. Initiation of a priority application. To initiate a priority application, the provider shall contact the county eligibility staff in the patient's county of residence and provide the following information.
1. The provider's name, address, and telephone number;
2. Patient's name and physical and mailing addresses;
3. Patient's telephone number and Social Security number if those numbers are known;
4. For a patient who is a dependent child, the parent's or responsible adult's name, address, and telephone number and Social Security number if available;

5. Patient's current physical location;
6. Name and address of the facility where treatment is, was, or will be provided;
7. Date and time of admission or initiation of treatment;
8. Expected duration of the medical treatment requiring hospitalization and discharge date and time, if known;
9. Description in layman's terms of the diagnosis, accident, or illness that resulted in the hospitalization;
10. 1st-and 3rd-party liability information, if known;
11. Date and time the provider contacts the county eligibility staff.

D. Processing of a priority application.
1. The date of a priority application is the day the provider contacts the county eligibility staff in the patient's county of residence.
2. Upon receipt of a priority application, the county eligibility staff shall schedule a face-to-face interview.
   a. If the county eligibility staff is able to meet in-person with the head-of-household, the county eligibility staff shall conduct the interview or schedule a mutually agreeable appointment time and provide the head-of-household with written confirmation of the appointment time.
   b. If the county eligibility staff is unable to meet in-person with the head-of-household, the county eligibility staff shall, within 3 working days following the date of a priority application, schedule an interview or attempt to contact the head-of-household to schedule an interview. The head-of-household may change the appointment 1 time if the request to change is made before the originally scheduled interview. The county eligibility staff shall then change the interview to a mutually agreeable time. If the county does not receive acknowledgment of the scheduled interview from the head-of-household, the county eligibility staff shall make at least 1 additional attempt to notify the head-of-household of the scheduled appointment.
3. The county eligibility staff shall determine eligibility under this Article.

E. Head-of-household's responsibilities. The head-of-household shall complete the application process under R9-22-1605.

F. Provider responsibility. If the county eligibility staff notifies the provider that the patient's eligibility may be dependent on incurred medical expenses, the provider shall make reasonable efforts to provide the county eligibility staff with timely information regarding amounts of billed charges and 1st- and 3rd-party liability for those changes.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1604. MI/MN Applications for Applicants Facing a Loss of Categorically Eligible Status Due to Termination of SSI Benefits

A. Postcard request for MI/MN coverage. A person who receives an AHCCCS categorical termination notice and a preprinted postcard under R9-22-1502 may initiate the application process for MI/MN eligibility by mailing or submitting the postcard to the county of residence eligibility staff within 7 days following the issuance date of the postcard. The date of the postmark or, if there is no postmark, the date of receipt by the county eligibility staff is the application date. The county eligibility staff shall prioritize the application process as follows:
1. If the preprinted postcard indicates that the person may be in immediate or ongoing need of medical care, the county eligibility staff shall determine the MI/MN eligibility within 20 days after the application date.
2. If the preprinted postcard indicates that the person may need a medical examination or medical care in the next 30 days or more, the county eligibility staff shall determine the applicant's MI/MN eligibility within 30 days after the application date.
3. If the circumstances described in subsections (A)(1) or (A)(2) are not applicable, the county eligibility staff shall determine the person's MI/MN eligibility within 60 days after the application date.

B. Initiating the eligibility process. If the county eligibility staff receives the preprinted postcard, the county eligibility staff shall initiate the MI/MN determination process by mailing to the applicant a notice that includes:
1. The fact that the county eligibility staff is prepared to take the MI/MN application and interview the applicant;
2. At least 1 interview date and time and the name of the county eligibility staff who will take the applicant's application and interview the applicant;
3. An instruction that the applicant shall immediately contact the county eligibility staff to select 1 of the scheduled interview dates and times or an alternative date and time;
4. A warning that failure to attend the scheduled interview without arranging an alternative interview may prevent the county eligibility staff from making an eligibility determination as specified under subsection (A);
5. A reminder that the applicant shall:
   a. Review the MI/MN eligibility and verification requirements that the applicant received with the notice of AHCCCS categorical termination, and
   b. Make every effort to obtain appropriate verification of information required to determine eligibility and bring it to the interview; and
6. An instruction that the applicant shall also bring the notice of termination of AHCCCS categorical eligibility to the interview.

C. Appointment scheduling. The county eligibility staff shall arrange the appointment at a time that permits an eligibility determination within the time limits established in subsection (A) but is not so close to the date of the postcard to be an undue burden on the applicant.

D. Termination notice as verification. The county eligibility staff shall accept the notice of AHCCCS categorical termination as verification of the applicant's Arizona residency, unless termination was due to nonresidence in Arizona.

E. Applicability of other requirements. Except as otherwise provided in this Section, all requirements of this Article applicable to applications for MI/MN coverage shall apply to applications initiated under this Section.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1605. Responsibilities of the Head-of-household for MI/MN Eligibility

A. Completion of the application. To complete an application for MI/MN coverage, the head-of-household shall:
1. Complete all required forms by:
   a. Answering each question completely and accurately in the Section provided, and
   b. Signing and dating each form;
2. Complete the face-to-face interview or, if permitted under R9-22-1608(D), telephonic interview, as scheduled;

3. Provide complete and accurate information regarding all factors that are necessary for determining eligibility;
4. Sign the Statement of Truth;
5. Obtain available verification specified in this Article and provide it to the county eligibility staff within the time limits in R9-22-1609;
6. Identify sources of necessary verification that are not provided under subsection (A)(5) and authorize the release of information to the county eligibility staff;
7. Identify all health or accident insurance policies and benefits and any cause of action against any applicant or entity that is potentially liable for costs incurred by household members;
8. Agree to file claims for 1st-and 3rd-party insurance benefits and to cooperate with the Administration to recover the cost of the medical care or treatment provided by the Administration including assigning rights to the Administration;
9. Complete the screening form and, if appropriate, application process for categorical eligibility under R9-22-1610; and
10. Sign a statement agreeing to cooperate with the application process for S.O.B.R.A. or other categorical eligibility if required, under R9-22-1610.

B. Reporting changes. The head-of-household shall:
1. Notify the county eligibility staff within 10 calendar days of any demographic or any other change that may affect eligibility; and
2. Provide information and verification necessary for processing an interim change under R9-22-1630 within 10 days following the county eligibility staff's written request.

C. Cooperation. The head-of-household shall cooperate with the Administration in a review of eligibility determination.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1606. MI/MN Statement of Truth by the Head-of-household

A. General requirements for the Statement of Truth.
1. The Administration shall publish a written Statement of Truth to be signed by the head-of-household in the presence of the county eligibility worker before an application is approved.
2. During the face-to-face interview, the county eligibility worker shall:
   a. Fully explain the Statement of Truth to the head-of-household,
   b. Request confirmation from the head-of-household that the Statement of Truth has been fully explained, and
   c. Request the head-of-household's signature only after the head-of-household confirms full understanding of the statement.

B. The Statement of Truth shall include:
1. The head-of-household's sworn oath or affirmation under penalty of perjury that all oral and written statements made as part of the application for AHCCCS coverage are true and correct to the best of the head-of-household's knowledge;
2. The requirement to report changes under R9-22-1630;
3. The requirement to provide DES, county, state, or federal reviewers with the information and verification of the information necessary to:
   a. Determine correct eligibility, or
   b. Conduct a quality control review;
4. The fact that refusal or failure to cooperate with the requirements of subsection (B)(3) shall result in the denial or discontinuance of AHCCCS coverage;
5. The fact that provision of incorrect information may result in denial or discontinuance;
6. An authorization for AHCCCS, the county eligibility staff, and DES to investigate and contact any sources necessary to establish the accuracy of information pertaining to eligibility for AHCCCS coverage;
7. The definition of fraud and the penalties that may result from fraudulently obtaining AHCCCS coverage;
8. The assignment and transfer to the Administration of all rights to insurance and any other 1st-and 3rd-party liability benefits, up to the actual cost of care received, accruing to the head-of-household or other household member during the certification period;
9. An agreement to apply for any health or accident insurance benefits to which an eligible household member is entitled;
10. An agreement that, if the need for medical treatment covered by AHCCCS is a result of negligence and if money or property is recovered by a household member from the negligent party or that party's insurer:
    a. AHCCCS and the health care provider shall be entitled to liens against the recovery, and
    b. That a release of a claim against the negligent party is not valid unless joined in by AHCCCS.
11. The head-of-household's right to appeal if:
    a. The county eligibility staff or DES takes adverse action on the application,
    b. The county eligibility staff does not take action on the application within 30 days following the application date and the head-of-household has not agreed to extend this time limit, or
    c. DES does not take action on the application within 45 days following the application date.
12. A statement that information contained in the case record is confidential and may be given only to certain persons as specified by law or regulation.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1607. Notice of Reapplication

The county eligibility staff shall notify the Administration if:
1. An applicant applies for MI/MN eligibility; and
2. Within the last 10 months, the head-of-household that included the applicant failed or refused to cooperate with the Administration's eligibility quality control review and analysis.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1608. County Responsibility for Completion of MI/MN Eligibility Determination

A. Provision of space. The county eligibility staff shall provide sufficient space and materials for the head-of-household to complete the application forms.

B. Provision of assistance. The county eligibility staff or a person authorized by the eligibility staff shall assist the head-of-household in completing the application forms if assistance is requested.
1. The person providing the assistance shall indicate on the form that assistance was provided.

2. The person providing assistance may provide assistance before or during the face-to-face interview.

C. Face-to-face interview. The county eligibility staff shall complete the face-to-face interview when the head-of-household is present at the scheduled appointment time. During a face-to-face interview, the county eligibility staff shall:
1. Inform the head-of-household of:
   a. The MI/MN eligibility requirements defined in this Article;
   b. The responsibilities of the head-of-household specified in R9-22-1605;
   c. The confidential nature of information received;
   d. The time-frames for completion of the application specified in R9-22-1609;
   e. The date coverage begins for approved applicants and the enrollment process;
   f. The length of certification period, under R9-22-1615, that may apply to approved household members;
   g. The E.P.S.D.T. benefits specified in R9-22-102, if there are children in the household; and
   h. The right to appeal specified in R9-22-802;
2. Present the Statement of Truth and obtain the head-of-household's signature under R9-22-1606;
3. Explain the requirement to screen for S.O.B.R.A. and other categorical eligibility under R9-22-1610 and provide each applicant with the appropriate screening form;
4. Obtain the head-of-household's signature on the Intent to Cooperate form and assist the head-of-household in the completion of additional forms for required applications under R9-22-1610;
5. Review each question on the application forms and supplements with the head-of-household and ensure that answers are recorded on the forms. Unless the applicant requests assistance in the completion of the application forms as provided in subsection (B), the county eligibility staff shall add information in the designated areas only; and
6. Request verification of information required under this Article.

D. Telephone interviews. The county eligibility staff may conduct a telephone interview if:
1. The person on whose behalf the application was initiated is a patient who is hospitalized:
   a. Outside of the patient's county of residence, or
   b. In the county of residence in medical isolation and there is no head-of-household in the county of residence who may apply on the patient's behalf; or
2. The head-of-household lives in a geographically isolated area identified by the Director; or
3. The person is an applicant with a disability and requests a reasonable accommodation, such as a sign language interpreter.

E. Eligibility worker responsibility during telephone interview. During the telephone interview, the eligibility worker shall:
1. Read the Statement of Truth to the head-of-household at the beginning of the telephone interview and determine the head-of-household's understanding;
2. Obtain demographic information about all household members and enter the information on the application forms;
3. Ask all questions on the application forms and obtain and record the answers;
4. Request the information and complete the screening form to identify potential S.O.B.R.A. and categorical eligibility under R9-22-1610;
5. Inform the head-of-household that verification of all information received during the telephone interview is required prior to the eligibility determination;
6. Inform the head-of-household of all factors listed in subsections (C)(1)(a) through (C)(1)(h);
7. Obtain confirmation of the household's mailing address and inform the head-of-household that all forms requiring signatures will be sent to that address and, except as provided in subsection (F), shall be signed and returned to the county eligibility staff within 30 days following the date of the application; and
8. Establish, by mutual agreement, follow-up arrangements to obtain verifications of all factors of eligibility and to obtain the required signatures.

F. Extension of 30-day time-frame. The county eligibility staff may extend the 30-day time-frame in subsection (E)(7) if the head-of-household remains incapacitated and unable to complete the application process. The extension ends when the conditions of either subsection (D)(1)(a) or (b) no longer apply.

G. Requirement to complete face-to-face interview. Except as permitted in subsection (D), the county eligibility staff shall complete an interview with the head-of-household before making an eligibility determination. After the interview, the county eligibility staff shall:
1. Complete any appropriate worksheets and other necessary forms to justify eligibility decisions;
2. Obtain the head-of-household's signature and date for any additional entries on the application;
3. Compare information received during and after the interview with existing case information to identify differences and to determine their effect on the eligibility determination;
4. Notify the Administration under R9-22-1618 if a household member is eligible;
5. Issue a Notice of Action under R9-22-1617;
6. Discontinue eligibility under R9-22-1617 and R9-22-1618 if a telephonic interview has been approved and after 30 days there have been no extensions or the end of the extension as specified in subsection (F); and:
   a. The county eligibility staff has not received the required verification, or
   b. The head-of-household has not signed and returned the required forms.

H. Statement of Completion. The Administration shall publish a Statement of Completion to be signed by the eligibility staff certifying completion of the application process.
1. The statement shall include the eligibility staff's confirmation that the eligibility worker has:
   a. Advised the person of:
      i. The right to appeal any eligibility decision,
      ii. The obligation to report all changes affecting eligibility, and
      iii. The penalties for fraud, misrepresentation, and intentional omissions;
   b. Requested and received confirmation that the person fully understands these rights, obligations, and penalties; and
   c. Completed the investigation of the AHCCCS eligibility required by law.
2. The county eligibility staff shall sign the Statement of Completion at the time of the eligibility decision except when the application is denied because an interview is not completed.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R.

294, effective January 8, 1999 (Supp. 99-1).

R9-22-1609. MI/MN Timeliness Requirements

A. Requirement for counties. Except for determinations for an applicant whose complete MI/MN-S.O.B.R.A. dual application has been forwarded to DES under R9-22-1610, the county eligibility staff shall make the eligibility determination within the 30 days following the application date. This 30-day limit may be extended under subsection (C).

B. Requirement for the head-of-household. The head-of-household shall provide the county eligibility staff with verification of information requested by the county eligibility staff under this Article by the 30th day following the application date.

C. Extension of an allotted time. The county eligibility staff shall extend the time period allotted in subsections (A) and (B) 1 time, by 30 days, if the head-of-household requests additional time to obtain or provide the requested verification and complies with subsection (D).

D. Informed consent. The county eligibility staff shall inform the head-of-household in writing that the requested extension may result in a delay or lapse in AHCCCS coverage. The head-of-household shall agree in writing to the extension and acknowledge the potential delay or lapse in AHCCCS coverage.

E. Extending time period. The county eligibility staff shall not extend the time period unless the county eligibility staff receives the signed agreement within the initial 30-day period.

F. Processing an untimely application. When processing an untimely application, for the purpose of counting income under R9-22-1626, the county eligibility staff shall base the 3-month income period on a deemed application date instead of the original application date.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1610. Forwarding Applications to Obtain Categorical Eligibility

A. Screening requirement. During or before the face-to-face interview, the county eligibility staff shall use the screening form required by A.R.S. §§ 36-2905, 36-2905.03, and 11-297 to screen all applications to determine each household member's potential for categorical eligibility.

B. A concurrent application for categorical eligibility. The head-of-household of a household that includes 1 or more of the following shall also apply at the same time for categorical coverage for the household member, unless the household member is already categorically eligible:

1. A pregnant woman;
2. A dependent child born on or after October 1, 1983;
3. A hospitalized applicant, not listed in subsections (B)(1) or (2), who is:
   a. A dependent child born before October 1, 1983;
   b. The parent or specified relative of a dependent child if;
      i. The child resides with a parent or specified relative, and
      ii. Deprivation exists under R9-22-1424; or
4. A nonhospitalized person not listed in subsections (B)(1) or (2) applying for SESP under R9-22-1613 who:
   a. Is listed in subsection (B)(3)(a),
   b. Is age 65 or older, or
   c. Claims blindness or disability as defined by 42 U.S.C. 1382c(a)(2) and (3).

C. Required cooperation. The head-of-household and household members listed in subsection (B) shall cooperate with the application process for categorical eligibility and shall sign a statement of Intent to Cooperate. The statement shall be on a form prescribed by the Administration and shall explain:

1. The requirement to concurrently apply for categorical eligibility, and
2. That failure to cooperate shall result in denial or discontinuance of eligibility.

D. Application forwarding requirements. If the household includes 1 or more persons who are listed in subsection (B), the county eligibility staff and the head-of-household shall complete the following:

1. The county eligibility staff shall assist the head-of-household for an applicant listed in subsections (B)(1) or (2) in completing an application for S.O.B.R.A. at the same time as completing the MI/MN application unless a pending S.O.B.R.A. application exists with DES. The county eligibility staff shall send the S.O.B.R.A. application to DES within 30 days following the date the county eligibility staff receives the signed application.
2. The county eligibility staff shall assist the head-of-household for an applicant listed in subsections (B)(3) or (B)(4)(a) to complete an application for medical assistance under R9-22-1407(D). The county eligibility staff shall forward the application and all available documentation and verification to DES under subsection (D)(4).
3. The head of a household that includes an applicant listed in subsection (B)(4)(b) or (c) shall apply for SSI-linked FESP for that person. The county eligibility staff shall forward the application forms, available documentation, and verification to the Administration under subsection (D)(4).
4. The county eligibility staff shall forward documents in subsections (D)(2) and (3) by:
   a. The 30th day after the date the county eligibility staff receives the signed application; or
   b. The 3rd day after the county completes the determination of eligibility, whichever date occurs 1st.
5. After the county eligibility staff forwards an application to DES or the Administration, the county eligibility staff shall not request additional verification from the household if that verification is necessary solely for determination of categorical eligibility other than S.O.B.R.A. The county eligibility staff shall continue to receive and forward to DES or the Administration any verification that was requested prior to forwarding the application or that was requested for the MI\MN determination.
6. Application forwarding requirements are waived if:
   a. The applicant listed in subsection (B) has an application for medical assistance pending determination by DES, or
   b. The applicant listed in subsection (B)(4) has an application for medical assistance pending determination by the Administration.

E. Conditions for approval. If the county eligibility staff forwards an application for an applicant listed in subsection (B) to DES or the Administration under subsection (D), the county eligibility staff shall not approve that applicant for coverage unless the applicant meets the requirements for eligibility under this Article and:

1. The applicant is hospitalized;
2. DES or the Administration denies the applicant's application for categorical eligibility for a reason other than refusal to cooperate; or
3. The applicant is listed in subsection (B)(1) or (2); and:
   a. The applicant meets the citizenship or alien status requirement for MI/MN eligibility under R9-22-1624;

b. The county eligibility staff forwards a complete application with all required documentation and verification to DES under subsection (D)(1); and
c. DES has not, within 10 working days following DES' receipt of the forwarded application, completed a determination of the applicant's eligibility for categorical eligibility.

F. County requirement to inform. Whenever the county eligibility staff is required to forward an application to another agency under this Article, the county eligibility worker shall explain to the head-of-household during the face-to-face interview:
1. That the application will be forwarded to another agency and the name of the agency,
2. What additional actions the head-of-household shall be required to take in order to establish eligibility,
3. The penalties for refusal to cooperate, and
4. The potential for delay in a determination of eligibility.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1611. Eligibility for Medicare Beneficiaries

A. Exceptions. This Section does not apply to a person who:
1. Has had an organ transplant requiring prescribed immunosuppressant drugs; or
2. May not be enrolled in a Medicare HMO because:
a. The person resides in a county where no Medicare HMO operates, or
b. The person has a preexisting medical condition or receives Medicare hospice services.

B. Eligibility restriction. A recipient of Medicare benefits is ineligible for MI/MN coverage if:
1. The person is enrolled in a Medicare HMO, or
2. The person voluntarily discontinued Part B Medicare benefits after being found ineligible for MI/MN under this Section.

C. Eligibility limitation. An applicant who is not enrolled in a Medicare HMO but is eligible or may be eligible to be enrolled in a Medicare HMO may receive MI/MN coverage, if eligible, with the following restrictions:
1. An person who has Medicare Parts A and B may receive MI/MN coverage for no longer than the month of certification plus the 2 following calendar months.
2. An person who receives Medicare Part A benefits, but who does not receive Medicare Part B benefits, may receive MI/MN coverage only:
a. Until the date that Medicare Part B benefits are available; or
b. Until the date Medicare Part B would be available if the person had applied for Medicare Part B benefits during the 1st Medicare general enrollment period following approval for MI/MN coverage.
i. Medicare general enrollment periods and resulting dates of Medicare Part B coverage are specified in 42 CFR 406 and 407.
ii. For this subsection, the Medicare general enrollment period ends if less than 1 month of the Medicare general enrollment period remains.
3. If an person becomes eligible for Medicare while MI/MN eligible, the county eligibility staff shall:
a. At the time of approval of MI/MN, advise the person to apply for those benefits during the initial Medicare enrollment period as specified in 42 CFR 406 and 407; and
b. Not approve a person for MI/MN coverage again, after the Medicare Part A and Part B benefits are effective, or would be effective if the person had applied for Medicare Part B benefits during the initial enrollment period.
4. The county eligibility staff shall provide the person a minimum of 2 months from the last day of the initial enrollment period to enroll in a Medicare HMO.

D. Undue Hardship. The Administration shall determine that a person has undue hardship if the applicant:
1. Meets all requirements for MI/MN benefits under this Article; and
2. Is determined ineligible for the Qualified Medicare Beneficiary and Specified Low Income Medicare Beneficiary program, as defined in A.R.S. § 36-2971 et seq., due solely to excess income and either:
a. Received Medicare Part A benefits as specified in 42 CFR 406 and 407 prior to July 1, 1996, and did not have Medicare Part B coverage as of July 1, 1996, or has applied to receive Medicare Part B; or
b. Received Medicare Part A and B or Medicare Part A benefits only and all Medicare HMOs operating in the applicant's county of residence charge a monthly premium.

E. Undue hardship payment:
1. The Administration shall reimburse the Medicare Part B premiums paid by the person who is subject to undue hardship under subsection (D)(2)(a).
2. The Administration shall pay Medicare HMO premiums directly to the Medicare HMO or reimburse Medicare premiums paid by the person who is subject to undue hardship under subsection (D)(2)(b). The Administration shall not pay:
a. More than the lowest Medicare HMO monthly premium available if there is more than 1 Medicare HMO in the applicant's county of residence, or
b. If coverage from a premium-free Medicare HMO becomes available in the applicant's county of residence.
3. Once every 6 months, the Administration shall review the status of each person who receives payments or on whose behalf payments are made for undue hardship under this Section. The Administration may approve an additional 6-month extension of the payments, provided the person continues to meet the requirements in subsection (D).

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1612. State-Funded Coverage for Children

A. Eligible low-income children program (ELIC).
1. Eligibility for ELIC coverage is determined by the county eligibility staff who shall determine eligibility for ELIC coverage for every child under age 14 who is a member of a household that is ineligible for MI/MN coverage due solely to exceeding income requirements of A.R.S. § 36-2905.
2. To be eligible for ELIC coverage under A.R.S. § 36-2905.03(C), a child shall:
a. Be a member of a household that:
i. Applies for MI/MN eligibility under this Article;
ii. Meets all eligibility requirements for MI\MN eligibility except has annual income determined under R9-22-1626 that exceeds the income limits prescribed by A.R.S. § 36-2905

but is less than or equal to the federal poverty limit established by the United States Department of Health and Human Services; and

b. Be under 14 years of age.

3. The county eligibility staff shall verify a child's age following the requirements of R9-22-1622 before approving ELIC eligibility for the child.
4. The county eligibility staff shall initiate a denial or discontinuance of ELIC eligibility for a child under age 14 if:
   a. A reason exists under R9-22-1616 to deny or discontinue MI/MN coverage except the income limit shall be as prescribed by A.R.S. § 36-2905.03(C), or
   b. The household limit exceeds the limit prescribed by A.R.S. § 36-2905.03.
5. The county eligibility staff shall initiate a discontinuance effective the end of the month of the ELIC child's 14th birthday.
6. Notices of Action for the ELIC program shall conform to the requirements of R9-22-1617.
7. The head-of-household for a child eligible for ELIC has all rights and responsibilities of a head-of-household for a child who is eligible for MI/MN.

B. MI/MN newborn eligibility.
1. A newborn child of an MI/MN mother is eligible for AHCCCS coverage from the date of the child's birth until the last day of the next month, if the child continues to reside with the MI/MN eligible mother;
2. To request continued coverage for the child beyond the time-frame in subsection (B)(1), the head-of-household shall report the birth to the county eligibility staff under R9-22-1630 or apply for redetermination under R9-22-1631.

C. Eligible assistance children program (EAC).
1. Eligibility for EAC coverage is determined by DES.
2. To be eligible for the EAC program, a child shall meet the requirements of A.R.S. § 36-2905.03(B).

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1613. State Emergency Service Program (SESP)

A. General Requirement. The county eligibility staff shall determine an applicant's eligibility for SESP only if:
1. The applicant applies for MI/MN coverage under this Article;
2. The applicant does not meet the citizenship or alien status requirement of R9-22-1624 or is unable to verify citizenship or alien status; and
3. The county eligibility staff determines that the applicant meets all other requirements in this Article for:
   a. MI/MN coverage, or
   b. ELIC coverage.

B. To be approved for SESP, an applicant shall:
1. Meet the requirements in subsection (A), and
2. Cooperate with the application for categorical coverage if required under R9-22-1610.

C. Face-to-face interview. During the face-to-face interview, the county eligibility staff shall fulfill the requirements of R9-22-1608 and explain the following to the head-of-household for an applicant who may be considered for SESP coverage:
1. Medical coverage is limited to emergency services designated by the Director;
2. Labor and delivery for a pregnant woman are covered. Prenatal care is covered only as indicated in subsection (D);
3. The requirement to provide verification of continued emergency medical services beyond the end of the month of approval; and
4. The procedure for having the certification period extended.

D. Prenatal care. A pregnant woman who is eligible for SESP is eligible for coverage of prenatal care if the pregnant woman has resided in the United States under color of law continuously since before August 22, 1996.
1. The county eligibility staff shall verify color of law by obtaining:
   a. The applicant's signature under penalty of perjury that the pregnant woman is lawfully residing in the United States;
   b. Unexpired documentation issued by the United States Department of Justice that the pregnant woman entered the United States before August 22, 1996, and is permitted to remain; and
   c. Verification that the woman is pregnant under R9-22-1615.
2. The pregnant woman shall apply for categorical eligibility and cooperate with the application process under R9-22-1610 but, if found eligible for that coverage, is eligible for prenatal care under SESP.
3. The county eligibility staff shall notify the Administration that the pregnant woman meets the eligibility requirements for prenatal care under SESP.
4. The certification period for prenatal care under SESP shall be the same as the certification period for SESP for a pregnant woman under R9-22-1615.

E. Extended certification. If eligible, an applicant shall receive an extended SESP certification period under R9-22-1615 by providing verification from a medical provider of continued need for coverage.

F. Denial or discontinuance of eligibility. The county eligibility staff shall deny or initiate discontinuance of a person's SESP eligibility if:
1. Reason exists under R9-22-1616, other than failure to meet citizenship or alien status requirements, to deny or discontinue MI/MN coverage;
2. The person or the head-of-household states that there is no need for medical services; or
3. The county eligibility staff approves or extends SESP coverage for months other than the month of determination under R9-22-1615, and the member, head-of-household, or provider informs the county eligibility staff that the member is no longer pregnant or no longer requires continued care under the program.

G. Notice of Action. Notices of Action for SESP shall conform to the requirements of R9-22-1617.

H. Rights and responsibilities. The head-of-household for an SESP applicant or member has all rights and responsibilities of a head-of-household for an MI/MN applicant or member under this Article.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1614. Reserved

R9-22-1615. Certification Periods

A. General certification period for MI/MN. The certification period for MI/MN coverage shall begin on the date of determination and, except as indicated in subsections (B) and (C), shall end on the last day of the 6th full calendar month following the date of determination.

B. Short certification period for MI/MN. The MI/MN certification period for a person shall begin on the date of determination and end on:
1. The same end date as already approved household members if the certification period is for an added household member or a household member whose eligibility is delayed; or
2. The last day of the 2nd full calendar month following the date of determination if the household member is:
   a. A Medicare recipient who is eligible to receive Medicare services from a Medicare HMO under R9-22-1611; or
   b. Hospitalized and potentially eligible for categorical coverage but not potentially eligible for S.O.B.R.A. At the end of the short certification period, the county eligibility staff shall extend the certification period to 6 months if the head-of-household cooperates with the DES application process and DES either denies categorical eligibility or has not completed the determination of the household member's categorical eligibility under R9-22-1414.

C. Extended certification period for an MI/MN pregnant woman.
1. The MI/MN certification period for a pregnant woman shall begin on the date of determination and end on the last day of the month after the estimated date of delivery or the end date under subsection (A), whichever date occurs last.
2. The pregnant woman shall provide verification of her pregnancy and estimated date of delivery. The verification shall be a written statement signed by a licensed physician, physician assistant, nurse, or midwife.
3. The county eligibility staff shall adjust an existing MI/MN certification period for a woman who provides verification to the county eligibility staff that she is pregnant, or that the estimated date of delivery is different from the originally verified date.

D. Certification period for ELIC. The certification period for ELIC coverage shall begin on the date of determination and end on the earliest date as follows:
1. The last day of the 6th calendar month following the date of determination,
2. The same end date as already approved household members if the certification period is for added household members or household members whose eligibility is delayed, or
3. The last day of the month of the household member's 14th birthday.

E. Certification period for SESP. The certification period for SESP shall begin on the date of determination and end on the last day of the month of determination.
1. The county eligibility staff may approve a longer SESP certification period under the following conditions:
   a. The county eligibility staff may initially approve or extend SESP certification period for up to 3 full calendar months if:
      i. A medical provider certifies that the applicant will need extended emergency medical care, or
      ii. A pregnant woman will still be pregnant during the additional months;
   b. The county eligibility staff may initially approve the month following the month of determination if the date of determination is 1 of the last 5 days in the month of determination.
2. The county eligibility staff shall not approve or extend an SESP certification period beyond:
   a. The last day of the month of delivery for a pregnant woman,
   b. The last day of the month of the child's 14th birthday for a child who is approved under R9-22-1613(A)(3)(b), or
   c. The last day of the 6th calendar month following the month of determination of the household's eligibility.
3. Before extending an SESP certification period, the county eligibility staff shall:
   a. Contact the head-of-household,
   b. Identify any interim changes, and
   c. Evaluate the effect of any interim change that occurred since the approval of eligibility under R9-22-1630.

F. Termination of certification period. The county eligibility staff shall discontinue eligibility and terminate the MI/MN, ELIC, or SESP certification period if a person becomes ineligible for coverage under this Article before the end of the certification period. Termination is effective:
1. On the date the county eligibility staff communicates the discontinuance to the Administration under R9-22-1618, if the reason for discontinuance is:
   a. A voluntary request for discontinuance by the head-of-household, or
   b. The person is an inmate in a public penal institution or is in a public mental hospital;
2. On the date of death if the member is deceased; or
3. For all other reasons:
   a. On the last day of the month that the county eligibility staff communicates discontinuance to the Administration under R9-22-1618, or
   b. On the last day of the following month if the county eligibility staff communicates discontinuance to the Administration after:
      i. 12:00 noon on the 2nd day before the last day of the month; or
      ii. The time that the Administration communicates, in advance, to the county eligibility staff.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1616. Denial or Discontinuance of MI/MN Eligibility

A. Ineligibility of households. The county eligibility staff shall send a denial or discontinuance notice for all household members under any of the following circumstances:
1. The household's annual income, determined under R9-22-1626, exceeds the limits specified in A.R.S. §§ 11-297 and 36-2905. The county eligibility staff shall not deny or discontinue eligibility if:
   a. A household member is incurring medical expenses that are eligible for deduction under R9-22-1626(F), and
   b. The household is expected to reach the allowable income limit within the 30 days following the application date.
2. The household's total countable liquid resources determined under R9-22-1627 exceed the $5,000 limit specified in A.R.S. §§ 11-297 and 36-2905.
3. The household's total countable resources determined under R9-22-1627 exceed the $50,000 limit specified in A.R.S. §§ 11-297 and 36-2905.
4. A household member transfers resources under R9-22-1628 for the purpose of meeting the resource limits specified in A.R.S. §§ 11-297 and 36-2905.

5. The head-of-household fails, within the time-frames as specified in R9-22-1609 or R9-22-1630, to provide information or verification required to determine eligibility. The county eligibility staff shall not deny or discontinue eligibility for this reason unless the required information or verification has been requested in writing by the county eligibility staff and the head-of-household has been given a minimum of 10 days from the date of a written request to provide the information or verification.
6. The head-of-household refuses to cooperate in providing information or verification that is required under this Article.
7. The head-of-household does not sign the application forms when required under this Article.
8. The head-of-household fails to participate in the face-to-face interview, under R9-22-1602, R9-22-1603, or R9-22-1631.
9. The head-of-household fails or refuses to cooperate with the application process under R9-22-1605.
10. The head-of-household requests a withdrawal of an application or discontinuance of all household members' eligibility for the program.
11. The head-of-household fails or refuses to cooperate with the Administration's eligibility quality control review or analysis.
12. The head-of-household refuses to assign health or accident benefits to the Administration as specified in R9-22-1605.
13. The applicant applying for the household is a dependent child, except as permitted under R9-22-1601(D).

B. Ineligibility of an individual household member. The county eligibility staff shall send a denial or discontinuance notice for an applicant under any of the following circumstances:
1. The person's whereabouts are unknown.
2. The person is not a resident of Arizona as defined in A.R.S. § 36-2903.01 and R9-22-1623.
3. The person is a dependent child whose application is not filed by a qualified applicant.
4. The person an inmate in a public institution.
5. The person is a patient of a public mental hospital.
6. The person is deceased. If the applicant dies and, within 2 days following the date of death, the county eligibility staff determines the applicant met all other eligibility requirements, the county eligibility staff shall approve the deceased applicant for MI/MN, ELIC, or SESP. The county eligibility staff shall then immediately discontinue the deceased applicant's MI/MN eligibility. This action will result in the availability of coverage under R9-22-1620, beginning 2 days before the date of determination and ending on the date of death.
7. The person is not a citizen of the United States or an alien under R9-22-1624.
8. The person is ineligible for coverage as specified in R9-22-1611.
9. The person is not a household member as specified R9-22-1625.
10. The person is eligible for medical assistance under Title XIX or Title XXI of the Social Security Act.
11. The person is an AHCCCS-disqualified spouse or an AHCCCS-disqualified dependent.
12. The person is ineligible for MI/MN, ELIC, or SESP coverage due to a refusal to cooperate with the Title XIX eligibility process as required by state law.
13. The head-of-household requests a discontinuance of the applicant's coverage.
14. The person is an adult and requests a discontinuance of the applicant's coverage.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1617. Notice of Action for Eligibility

A. General requirement. The county eligibility staff shall prepare a Notice of Action stating the county eligibility staff's determination of each household member's eligibility or ineligibility and of any changes in eligibility status.

B. Form of the Notice of Action. The notice shall be on a form prescribed by the Administration.

C. Required information. The notice shall include the following information:
1. The program for which the county eligibility staff is making the determination,
2. The type of action,
3. The effective date of the action under R9-22-1615,
4. The end date of newly approved or existing coverage even if unchanged,
5. The right to request a hearing and the procedure and time limits for making the request,
6. The address and telephone number of the county eligibility office where the determination is completed,
7. The name or the identification number registered with the Administration of the eligibility worker who completes the eligibility determination, and
8. The date the notice is mailed or hand-delivered to the head-of-household.

D. Notices of adverse actions. A notice of denial, discontinuance, or proposed discontinuance shall include the reason for the action and the law or regulation.

E. Avoidance of proposed discontinuance. A notice of proposed discontinuance shall include an explanation of the right to provide proof of eligibility within 15 days following the notice to avoid discontinuance under R9-22-1619.

F. Distribution of the notice to the head-of-household. On the date of determination, the county eligibility staff shall send the Notice of Action by mail or deliver it personally to the head-of-household.

G. Notice to providers. The county eligibility staff shall notify the provider who initiated the application for a household member under R9-22-1603 of the household member's eligibility or ineligibility.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1618. Communication of Eligibility Determinations to the Administration

A. General. The Administration shall process eligibility actions communicated to the Administration by the county eligibility staff.

B. Communication. With the exception of denials, the county eligibility staff shall communicate demographic changes and all eligibility actions to the Administration by telephone or by other means approved by the Administration.

C. Information. The county eligibility staff member shall provide the following to the Administration:
1. The staff member's identification number and eligibility site;
2. The type of action;
3. Personal and demographic information about the applicant for whom the action is taken;

4. The AHCCCS recipient and case identification numbers, if available;
5. The beginning date and the end date of eligibility, as appropriate; and
6. Other information that the Administration requests in writing.

D. Time-frames.
1. The county eligibility staff shall provide the Administration the following information on the date of determination:
   a. Approval or extension of eligibility;
   b. Discontinuance of eligibility if the county eligibility staff receives verification that the applicant:
      i. Is an inmate in a public institution or in a public mental hospital,
      ii. Does not reside in Arizona,
      iii. Is eligible for Title XIX coverage in another state or territory, or
      iv. Is deceased; and
   c. Discontinuance of eligibility if the head-of-household or an adult household member submits a written request for discontinuance.
2. The county eligibility staff shall communicate a discontinuance of eligibility for any other reasons on the 16th day following the date of determination.
3. The county eligibility staff shall communicate demographic changes that do not affect eligibility on the day that the county eligibility staff verifies the change.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1619. Rights Following Receipt of a Notice of Denial or Discontinuance of Coverage
A member or head-of-household may take the following actions in response to an adverse action by the county eligibility staff:
1. Apply again for eligibility under this Article;
2. Appeal the denial or discontinuance under R9-22-802; or
3. Stop a proposed discontinuance by providing proof of eligibility to the county eligibility staff within 15 days after the date of the Notice of Action.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1620. Retroactive Coverage for MI/MN, ELIC, and SESP
The Administration or contractors shall be responsible for covered emergency medical services as defined by R9-22-102 which are provided to a MI/MN, ELIC, or SESP eligible person during the 2 days before the date that a county eligibility staff determines a person eligible and the county communicates the eligibility determination to the Administration as specified in R9-22-1618. The Administration shall not be responsible for the costs of emergency medical services that are deducted from the household's annual income under R9-22-1626.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1621. Reserved

R9-22-1622. Verification of Information for MI/MN Eligibility

A. Verification. The applicant shall provide the county eligibility staff with verification of all information necessary to complete the determination of eligibility in the initial application process or at the time of a redetermination or interim change.
1. The county eligibility staff shall not approve an applicant's eligibility until all required verification is received.
2. The county eligibility staff shall offer to assist the applicant in obtaining verification and shall provide assistance if authorized by the applicant.

B. Procedure for obtaining verification. Except where otherwise indicated in this Article, the county eligibility staff shall adhere to the following procedure for requesting and obtaining verification:
1. The county eligibility staff shall 1st request documented verification that is available at the time of the interview. Documented verification is evidence in written form provided on an official document from an applicant qualified to have knowledge of the information provided. Documented verification shall be secured from the applicant or from a 3rd-party.
2. If documented information is not immediately available at the time of the interview, the county eligibility staff shall accept collateral verification. Collateral verification is information presented other than on an official document and obtained from a person who has knowledge of the information. The applicant shall identify potential sources of collateral verification for each item of information.
3. If sources of collateral verification are not available, the county eligibility staff shall request that the applicant obtain documented information that is not immediately available at the time of the interview.
4. If the county eligibility staff and the applicant exhaust all potential sources of collateral and documented verification and determine that documented and collateral verification are not available, the county eligibility staff shall accept a written declaration as verification. The written declaration shall be signed and dated by the head-of-household.
   a. Verification is not available if:
      i. A record does not exist for the information that needs to be verified, or
      ii. A record exists but the person or entity able to provide the information refuses to provide it to both the county eligibility staff and the applicant.
   b. Verification that is available only upon payment of a fee is not considered unavailable.

C. Reverification waiver. The county eligibility staff shall not reverify information for determinations or redeterminations of eligibility if information that is not subject to change is contained in case records and verified under this Article.

D. Resolution of inconsistencies required. The county eligibility staff shall reconcile any inconsistencies between the verified information and the case file before approving eligibility unless the inconsistencies have no effect on the eligibility determination.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1623. Residence Requirements for MI/MN Eligibility

A. General Requirements. To be eligible for MI/MN coverage, an applicant shall be a resident of Arizona. An MI/MN applicant may establish Arizona residency on behalf of all members of the household by:
1. Signing an affidavit attesting to:

a. Current residence in Arizona and intent to remain indefinitely, and
b. Abandonment of residency outside of Arizona; and
2. Meeting the Arizona residency requirements under A.R.S. § 36-2903.01.

B. Residency of household groups. If the head-of-household meets the requirements of subsection (A), the county eligibility staff will consider the residency requirements met for all household members unless the county eligibility staff has evidence that:
1. A dependent child household member may not meet the requirements of subsection (A). The head-of-household shall provide documented or collateral verification as defined in R9-22-1622, showing the child resides with the household; or
2. An adult household member may not meet the requirements of subsections (A) and (B). An adult household member shall independently establish Arizona residency as specified in this Section.

C. Frequency of required verification. The county eligibility staff shall verify Arizona residency:
1. For the household before approving any application except an application for redetermination; and
2. For a household member;
a. Any time the county eligibility staff questions residency for the household member, or
b. Before the county eligibility staff adds a household member to the household.

D. Determinations by a County Special Eligibility Officer. If a County Special Eligibility staff determines residency as specified in A.R.S. § 36-2903.01, the County Special Eligibility staff shall not make a determination of residency based solely on the Statement of Truth or a statement of intent and shall require collateral verification.

E. Retention of residency. The county eligibility staff shall not consider an absence from the state longer than 60 consecutive days to be temporary unless good cause is established for a longer absence.
1. A person shall continue to be an Arizona resident during a temporary absence from the state if the person does not establish a permanent residence outside of Arizona and continues existing Arizona-linked activities including:
a. Motor vehicle registration,
b. Income tax filing,
c. Voter registration, and
d. Receipt of Arizona public assistance.
2. A person shall report, in advance to the county eligibility staff, an absence from the state that is expected to last more than 60 consecutive days.

F. Verification of county residency. The head-of-household shall confirm the county of residence of the household by:
1. Providing 3rd-party documented or collateral evidence of the household's residential address or physical location if no permanent residence exists, and
2. Signing a statement that all members of the household reside in the county.

G. Opportunity to establish residency. The head-of-household or spouse shall be given 30 days from the application date, or until determined ineligible for another reason, to meet the requirements of this Section. The time may be extended for an additional 30 days under R9-22-1609.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1624. Citizenship and Alien Status Requirements for MI/MN Eligibility

A. General requirements. To be eligible for MI/MN coverage, an applicant shall be a United States citizen or meet the alien status requirements of A.R.S. § 36-2903.03.

B. Affidavit**.** Each adult applicant shall sign an affidavit under penalty of perjury that the applicant is a citizen of the United States or an alien with lawful alien status. A parent, specified relative, or legal guardian shall sign the affidavit for each minor in the household. This requirement does not apply to an applicant who verifies citizenship under subsections (C)(1), (2) and (3).

C. Verification of citizenship. The head-of-household shall provide the county eligibility staff with documentation of United States citizenship for all applicants who are citizens. Documentation is 1 of the following:
1. A birth certificate issued by any state or the District of Columbia or an outlying possession of the United States;
2. A religious certificate, recorded in the United States within 3-months following birth, indicating birth in the United States or outlying possession of the United States;
3. A document issued by the United States Department of State or the United States Department of Justice indicating that the applicant is a citizen of the United States;
4. An affidavit, signed under penalty of perjury, attesting to birth in the United States or 1 of its outlying possessions.
a. A parent or specified relative may sign on behalf of a dependent child. All other household members shall sign the affidavit;
b. The affidavit of birth may be combined with the affidavit of citizenship required under subsection (B);
5. Verification of registration to vote in the United States; or
6. A document or documents not listed in this subsection that verify that the applicant is a citizen of the United States at birth under 8 U.S.C. 1401.

D. Lawful alien status. The head-of-household shall provide the county eligibility staff with documentation of lawful alien status for all applicants who claim to be lawful aliens. Documents of lawful alien status are:
1. Documents issued by the United States Department of Justice verifying that an applicant is a qualified alien under A.R.S. § 36-2903.03 and the applicant's date of legal entry into the United States;
2. Documents indicating that the applicant is a Native American born in Canada and has at least 50% Native American ancestry.
3. Documents indicating that the applicant, who was born outside the United States and cannot verify United States citizenship under this Section, is a member of an Indian Tribe as defined in 25 U.S.C. 450 b(e).

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1625. Household Composition for MI/MN Eligibility

A. Identification of household. A household consists of:
1. A single person residing alone;
2. All persons who normally share a common residence and are linked by any of the following relationships:
a. Spouse to spouse,
b. Parent to dependent child whether natural or adopted, or
c. Specified relative to dependent child;
3. A spouse living separately from members of the same household if:

a. A spouse resides in Arizona in a licensed nursing care institution, licensed supervisory care facility, or certified adult foster care facility because of a mental or physical disabling condition verified by doctors; or
b. A spouse is temporarily absent, under R9-22-1623(E), from the common residence due to working or seeking employment away from the common residence; or

4. A dependent child who is absent from the home because of school attendance within Arizona or because of residence in a residential facility is a member of the child's parent's household unless:
a. The child lives with the other parent,
b. The child lives with a specified relative,
c. The child is pregnant, or
d. The child lives with the child's own children.

B. Exclusions from the household. The following persons are not members of the household. The county eligibility staff shall not exclude any other person who is a member of the household under subsection (A).

1. Except as provided by A.R.S. §§ 11-297, 36-2905, and 36-2905.03, a person who is eligible as any of the following is not a member of the household unless that person is a person for MI/MN eligibility due to termination of categorical eligibility within 30 days before termination from categorical eligibility:
a. A categorically eligible person who is covered for all medical services under A.R.S. § 36-2907, or
b. A Qualified Medicare Beneficiary under A.R.S. § 36-2971.
2. A dependent child who is pregnant or who is a parent who resides with that dependant child's own children and with a specified relative, is not a member of specified relative's household, unless the specified relative is the dependent child's legal guardian.

C. Verification of relationship and household composition. The county eligibility staff shall verify relationship and living arrangements including absent spouses or absent children under subsections (A)(3) and (4) whenever:

1. There is a change in address; or
2. Before approving MI/MN eligibility.
a. The county eligibility staff may accept a declaration of the head-of-household for verification that applicants reside together unless it is inconsistent with other information known to the county eligibility staff;
b. The county eligibility staff shall verify the reason for absence of absent household members under R9-22-1622.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1626. Annual Income for MI/MN Eligibility

A. Determination of annual income. The county eligibility staff shall determine annual income under A.R.S. §§ 36-2905, 11-297, and 36-2905.03 by:

1. Adding any countable income received during the 3-month income period by:
a. Household members;
b. A trust if the resources of the trust are included in determining the household's resources under R9-22-1627;
c. A corporation if the resources of the corporation are included in determining the household's resources under R9-22-1627. The county shall calculate the income received and expenses incurred by such a corporation the same as self-employment income and expenses of a household member;
2. Multiplying the result of subsection (A)(1) by 4;
3. Deducting medical expenses that are deductible under subsection (F); and
4. If the applicant is a qualified alien who has a sponsor under A.R.S. § 36-2903.03, adding the annual income of the sponsor and the spouse of the sponsor.
a. The county eligibility staff shall determine and verify the sponsor's and the sponsor's spouse's annual income by the same procedure used to determine the applicant's annual income under this Section.
b. The county eligibility staff need not conduct a face-to-face interview with the sponsor or the sponsor's spouse for this purpose.

B. Receipt of income. Except as indicated in subsection (C), the county eligibility staff shall consider income available to the household to be received on the earliest of:

1. The date it is received by a household member, made available to be picked up by a household member, or paid to someone else on a household member's behalf. Payment may be in the form of cash, check, or other negotiable instrument.
2. The date the household member receives a check in the mail if the check is not available to be picked up by a household member. This date may be:
a. The date on the check if the check is mailed before the date on the check so as to be received on the date of the check;
b. The 5th day after the date on the check if the check is mailed on the date printed on the check; or
c. A later date if later receipt is verified under R9-22-1622;
3. On the date the income is deposited in a bank or other financial institution by any entity or applicant, including another owner of the account, into an account that is owned under R9-22-1627 by a household member.

C. Deemed date of receipt. The county eligibility staff shall consider income to be received on a date other than the date it became available if the income:

1. Is available annually, semi-annually, or at another regular periodic interval of more than 3 but no more than 12 months:
a. The county eligibility staff shall divide the income by the number of weeks between payments; and
b. The county eligibility staff shall consider 1 portion received weekly until exhausted, beginning on the date the income is available under subsection (B);
2. Is available as a lump-sum at the option of the recipient or of the payor. The county eligibility staff shall consider lump-sum income received in portions on the dates the portions would be or would have been available if paid separately and not in a lump sum;
3. Is 1-time income that is not lump-sum income but is designated by the payor to cover a specified period of time:
a. The county eligibility staff shall divide these payments into a number of portions equal to the number of weeks in the specified period; and
b. Shall consider 1 portion received weekly until exhausted, beginning on the date the income is available under subsection (B); or
4. Is 1-time-income that is not designated by the payor to cover a specified period:

a. The county eligibility staff shall divide these payments into 4 equal portions, and
b. Shall consider 1 portion received on the day it is available under subsection (B) and 1 portion received on the same day of each 3rd month until the income is exhausted.

D. Disregarded income. The following income shall be disregarded for purposes of determining eligibility for this Article:
1. Income received from a household member under R9-22-1625;
2. Income received from a categorically eligible person who resides with the applicant and except for categorical status would be a member of the household.
3. Income earned by a dependent child until the child's 16th birthday if the child is not emancipated or expressly emancipated;
4. Income received as conversion of assets;
5. Income in-kind;
6. Gratuitous payments made directly to a 3rd-party by friends, relatives, charities, or agencies on behalf of the applicant or household;
7. Reimbursement for medical care received from a 1st- or 3rd-party liability source;
8. Reimbursement for loans to or expenditures made on behalf of a nonhousehold member;
9. A loan received by a household member, to the extent that the loan is repaid by a household member before the application date or, if not repaid, there is a dated, written repayment agreement at the time of the financial exchange, which is signed by the household member;
10. The 1st of 4 regular monthly income or the 1st of 7 regular 2-times-a-month income that is received during the 3-month income period, if those payments are to the same household member from the same payor;
11. Loans, grants, scholarships, and fellowships funded by the United States Department of Education or benefits received under the Veterans Education Assistance Program or the Bureau of Indian Affairs student assistance program for educational purposes;
12. Educational, commuting, relocation, and job search allowances provided under the Trade Readjustment Act;
13. Reimbursement for training-related expenses, subsistence and maintenance allowances, on-the-job training wages, or other wages related to vocational rehabilitation and paid to applicants engaged in a veteran, federal, or state-sponsored vocational rehabilitation program;
14. VISTA volunteer compensation;
15. Compensation paid to volunteers over age 60 in the Retired Senior Volunteer Program, the Foster Grandparent Program, and the Older American Community Service Program;
16. Tax credit granted under A.R.S. § 43-1072, earned credit for property taxes for residents 65 years of age or older;
17. Indian Claims Commission or Court of Claims judgment funds (also known as per capita payments to Indian tribes), including interest on the funds while in trust, regardless of the tribe or the public law number;
18. Alaska Native Claims Settlement Act benefits that are tax exempt;
19. Emergency Disaster and Energy Assistance Payments;
20. Public relocation assistance payments;
21. Condemnation awards for the condemnation of the principal place of residence;
22. Income that an applicant or the applicant's household receives as a result of a settlement agreement or a judgment in a lawsuit brought against a manufacturer or distributor of Agent Orange;
23. Reparation and restitution payments under 42 U.S.C. 1396a(r); and
24. Refunds of state and federal income tax payments.

E. Deductions from income. The county eligibility staff shall allow the following deductions from gross income that is not disregarded in determining eligibility:
1. Court-ordered spousal maintenance, division of income, alimony, or child support owed by a household member that is paid by a household member during the 3-month income period;
2. Unreimbursed employee work-related expenses that were paid by a household member during the 3-month income period may be deducted from earned income only. These include:
   a. Expenses incurred solely because they are required by the employer,
   b. Union or association dues, and
   c. Employment agency costs.
3. Cost of child care or disabled dependent care incurred because of employment or job search or both paid by a household member during the 3-month income period;
4. Educational expenses including tuition, books, lab fees, other mandatory student fees;
   a. The county eligibility staff may deduct educational expenses only from countable educational income;
   b. If the county eligibility staff determine that educational income from which the expense is deducted is deemed received over time under subsection (C), and the expense is for tuition or other costs for the same time period, the county eligibility staff shall deduct the entire expense from the income before dividing the income;
5. Expenses of producing self-employment incurred during the 3-month income period. The county eligibility staff may deduct self-employment expenses only from self-employment income;
6. The amount deducted from income for the purpose of repaying an overpayment to a household member;
7. Legal and attorneys' fees withheld from a settlement or judgment that results in income to a household member;
8. Funeral and burial expenses. The county eligibility staff may deduct these expenses only from death benefit income; and
9. Income received by a household member as a representative, on behalf of another person who is entitled to the income, to the extent that it is not used for the representative or the representative's household.

F. Medical expense deduction. The county eligibility staff shall subtract deductible medical expenses when determining the household's annual countable income. The county eligibility staff may deduct only those medical expenses that:
1. Were incurred by:
   a. A household member,
   b. A person who would be a household member but for exclusion under R9-22-1625(B),
   c. A deceased spouse or dependent child of a household member, or
   d. A person who was a dependent child of a household member when the expense was incurred but who is no longer a dependent child;
2. Were incurred during the 12 months immediately before the date of determination for eligibility;
3. Are not subject to any applicable 1st- or 3rd-party payment or payment by the Administration; and

4. Are the financial responsibility of a household member. Costs are not a household member's responsibility if the costs have not been paid by a household member and:
   a. Another person has paid them without expectation of repayment,
   b. Another person has paid the expenses as a loan but there is no repayment agreement signed by the household member charged with making the repayment,
   c. The creditor has canceled the charges before the eligibility determination, or
   d. The charges are owed to the Administration and the Administration has taken no action and there is no plan to collect the amount.

G. Income verification exceptions. The county eligibility staff shall verify all information pertaining to the calculation of annual income under the requirements specified in R9-22-1622 except:
1. For verification of self-employment income, the head-of-household's declaration may serve as the primary verification source;
2. The county eligibility staff shall accept only documented or collateral verification for:
a. Self-employment expenses deducted under subsection (E)(5); and
b. Deductible medical expenses; and
3. The county eligibility staff may not accept the declaration of the head-of-household or the sponsor of a qualified alien or sponsor's spouse as verification of the sponsor's or sponsor's spouse's income.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1627. Resources for MI/MN Eligibility

A. When to calculate resources. The county eligibility staff shall evaluate the value of resources as of the application date or latest interim change under R9-22-1630, whichever date occurred last.

B. Included resources. The county eligibility staff shall include the following resources in determining eligibility:
1. Owned by household members as defined in R9-22-1625, except resources excluded in subsection (D). The owner of the resources is the person who holds legal title to or provides evidence of ownership of a resource if no valid title exists;
   a. If a liquid resource is owned by more than 1 person, the liquid resource shall be counted in full unless:
      i. The applicant demonstrates by clear and convincing evidence that all or part of the resource is unavailable, and
      ii. The applicant has neither contributed to nor benefited from the liquid resource; and
   b. If a nonliquid resource is owned by more than 1 owner, the nonliquid resource shall be presumed owned by all owners in equal shares unless the applicant demonstrates by clear and convincing evidence that a different allocation shall be used, based upon each owner's proportionate net contribution;
2. Resources held in trust if:
   a. The trust is funded with resources owned by or due to a household member and a household member is a beneficiary,
   b. The trust is funded by a nonhousehold member and the trustee and all beneficiaries are household members, or
   c. The trust is funded by a nonhousehold member and the trustee is a household member and has the ability to withdraw funds from the trust for the trustee's own use;
3. Resources owned by a corporation if all shares of the corporation are owned by household members;
4. Resources owned by a sponsor of a qualified alien applicant, or the sponsor's spouse, if those resources are included under A.R.S. § 36-2903.03.
   a. The county eligibility staff shall verify the sponsor's or the sponsor's spouse's resources as specified in subsection (F).
   b. The county eligibility staff is not required to conduct a face-to-face interview with the sponsor or the sponsor's spouse.

C. Calculation of resources: The county eligibility staff shall determine the value of all household resources as follows:
1. Except as specified in subsection (E), calculate the total amount of the liquid resources.
2. Calculate the equity value of each nonliquid resource:
   a. The county eligibility staff shall use the assessor's full cash value as the value of real property, except the county eligibility staff shall use the market value of real property if:
      i. The assessor's value of real property does not include the value of permanent structures on that property, or
      ii. There is no assessor's evaluation of the property,
   b. The county eligibility staff shall use the market value of all other nonliquid resources;
   c. The county eligibility staff shall determine a household member's equity of a nonliquid resource by subtracting the amount of valid encumbrances on that resource from the assessor's full cash value or market value of the nonliquid resource;
   d. The equity value of a resource shall not be less than 0; and
3. Determine the net worth of all household resources by adding the totals determined in subsections (C)(1) and (C)(2).

D. Excluded resources. When determining the value of resources owned by the household the county eligibility staff shall not count the value of:
1. Household furnishings;
2. Personal items and clothing;
3. Household pets;
4. Property that is not available because it is the subject of litigation in a court of law;
5. The unexpended portion of educational grants, loans, scholarships, and fellowships left on account in a financial institution during the period of time for which the funds were intended;
6. Public relocation assistance moneys;
7. Separate property of an AHCCCS-disqualified spouse up to $75,000. The county eligibility staff shall calculate the value of an AHCCCS-disqualified spouse's property under subsection (C);
8. Tools and machinery used for business excluding cars, trucks, or other motor vehicles;
9. Business inventory;
10. Tools and machinery not used for business if the aggregate value is $500 or less;
11. Wedding rings and engagement rings;
12. Money that an applicant or the applicant's household receives as a result of a settlement agreement or a judg-

ment in a lawsuit against a manufacturer or distributor of Agent Orange if the money is identifiable and held separately from other money; and

13. Funds from reparation and restitution payments under 42 U.S.C. 1396a(r).

E. Provision for special treatment. For the purposes of this Section, the following resources shall be counted as nonliquid:

1. Condemnation awards of the principal place of residence, up to the assessed value of the property, for 12 months from the date of receipt or until the date of purchase of a new principal place of residence, whichever date occurs 1st; and
2. The principal balance due on a written sales contract or mortgage if the seller no longer owns the resource sold.

F. Verification of resources. The ownership and value of all property and resources for household members shall be verified prior to an eligibility determination under the requirements and time-frames specified in R9-22-1622, except:

1. The head-of-household's declaration shall not be accepted to verify an encumbrance if subtraction of the amount of the encumbrance is necessary to bring the household's resources within the resource limits specified in A.R.S. § 36-2905.
2. Once verified, the county eligibility staff shall not reverify the ownership and value of real property more than annually unless the household is within $5,000 of the total resource limit specified in A.R.S. § 36-2905.
3. The head-of-household's declaration of value for cash on-hand, jewelry, and tools and machinery shall be acceptable verification unless there is reason to believe an appraisal of any item might result in ineligibility.
4. The value of excluded nonliquid resources, other than separate property of an AHCCCS-disqualified spouse, shall not be verified.
5. The county eligibility staff shall not accept the declaration of the head-of-household or the sponsor of a qualified alien or sponsor's spouse as verification of the sponsor's or sponsor's spouse's resources.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1628. Transfer of Resources for MI/MN Eligibility

A. Ineligible members. All household members are ineligible if 1 household member transfers ownership of resources to a nonmember of the household within 3 years before the application date, unless:

1. Fair consideration was received for the entire value of transferred resources:
   a. Fair consideration for transferred resources means:
      i. 100% of the value if liquid resources are received in return for liquid resources transferred;
      ii. 100% of the value if debt is canceled in return for liquid resources transferred. Cancellation of debt is fair consideration only if the debt is legally enforceable and owed by a household member or a person who would be a household member except for categorical eligibility; and
      iii. 80% of the value transferred for transfers not included in subsections (A)(1)(a)(i) and (A)(1)(a)(ii);
   b. The county eligibility staff shall combine all consideration received for a transferred resource when determining whether fair consideration was received;
2. The entire equity value of the resource at the time of transfer, if added to the equity value of all other resources owned at the time of transfer, does not result in ineligibility;
3. Foreclosure or repossession of the resource was imminent at the time of transfer and there is no evidence of collusion in the transfer; or
4. The person who transferred the resources or the head-of-household establishes by clear and convincing evidence that the transfer was not made for the purpose of establishing eligibility.

B. Requirement for verification. The applicant for MI/MN coverage shall provide verification of:

1. The type, values, and equity of:
   a. All resources transferred during the 3 years before the application date,
   b. All resources owned at the time of the transfer, and
   c. All consideration received;
2. Imminent foreclosure for real property; or
3. Other reasons for transfer.

C. Form of verification.

1. A household member's declaration may be used to verify:
   a. The value and equity of all transferred resources, other than real property, at the time of transfer; and
   b. The value and equity of resources, other than real property, owned at the time of the transfer.
2. All other information requiring verification shall be verified under R9-22-1622.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1629. Assignment of Rights

A. Assignment. As a condition of MI/MN eligibility, the head-of-household shall assign to the Administration the rights of all household members to medical support or payment of medical care from any liable party.

B. Assistance. The head-of-household shall identify and assist the Administration in pursuing 1st- or 3rd-party liability as defined in R9-22-101.

C. Verification. The county eligibility staff shall request and obtain verification information under R9-22-1622 for the 3rd-party liability.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1630. MI/MN Interim Changes

A. Reporting requirements. The head-of-household shall report the following interim changes to the county eligibility staff by the 10th day following the change:

1. Change in household composition under R9-22-1025;
2. Change of address;
3. Increase in income due to increased salary, wages, unearned income, increased hours, a new job, gifts, inheritances, a legal settlement, or another new unreported source of income;
4. Addition to existing resources other than those resulting from the receipt of already reported income;
5. Change in alien status;
6. Change in 1st- or 3rd-party liability for health care expenses; or
7. Pregnancy of a household member or termination of a household member's pregnancy.

B. Processing other changes. If the county eligibility staff receives a report of an interim change identified in this Section

from any source during a household member's certification period, the county eligibility staff shall identify any additional related changes and evaluate the effect of all changes on eligibility for continued benefits.

1. If verification of information is required to determine ongoing eligibility, the county eligibility staff shall request the verification required under R9-22-1622 from the head-of-household. The county eligibility staff shall make the request in writing within 2 working days from the date a change is reported. The county eligibility staff shall allow the head-of-household 10 days following the date of written request to supply the verification and information requested.
2. Except as indicated in subsection (B)(3), upon receipt of required verification, the county eligibility staff shall evaluate interim changes under this Section. Upon completion of the evaluation of any change, the county eligibility staff shall provide notice of the result to:
   a. The head-of-household, under R9-22-1617, if the reevaluation results in:
      i. Discontinuance,
      ii. Change in coverage, or
      iii. Change in the certification period; or
   b. The Administration, under R9-22-1618, if the change;
      i. Adds a new eligible member,
      ii. Affects an existing member's eligibility or certification period,
      iii. Is demographic, or
      iv. Is for 1st-or 3rd-party liability for a member's health care.
3. If the county eligibility staff receives a report of an interim change less than 60 days before the end of the certification period, the county eligibility staff shall redetermine the household's eligibility under R9-22-1631.

C. Changes in household composition.

1. The head-of-household shall submit a new Part I Application to the county eligibility staff if there is a change in household composition.
2. If the county eligibility staff receives an application to add an applicant to a household that includes members who are eligible for MI/MN, ELIC, or SESP, the county eligibility staff shall:
   a. Evaluate the effect of the applicant's income or resources on the household's eligibility under subsections (D) and (E);
   b. If additional income and resources do not make the household ineligible and the additional applicant meets the requirements for eligibility, approve the additional applicant for coverage;
   c. Evaluate whether the applicant meets all other eligibility requirements under this Article;
   d. Screen the applicant for potential categorical eligibility under R9-22-1610 and, if appropriate, complete and refer the application to other agencies; and
   e. If added income and resources do not make the household ineligible, but the added applicant does not meet another requirement for eligibility, deny the added applicant for coverage.
3. If a person is no longer in the household, the head-of-household shall report the change to the county eligibility office and identify the remaining members of the household. The county eligibility staff shall:
   a. Discontinue eligibility for the person who is no longer a household member;
   b. Require redetermination of the household's eligibility under R9-22-1631, if the person is an adult who no longer resides with the household; and
   c. In all other cases, recalculate the annual income of the remaining household members only, based on their income and medical expenses used for the determination when eligibility was last approved:
      i. Compare the result to the income limit under R9-22-1626 for the adjusted household size, and
      ii. If the result is greater than the income limit, require a redetermination of the household's eligibility under R9-22-1631.

D. Changes in income. If a household reports and provides verification of additional income from increased salary, wages, unearned income, increased hours, a new job, gifts, inheritances, legal settlements, additional household members, or other new sources, the county eligibility staff shall:

1. Evaluate the effect of the income that is new or changed on the household's eligibility by:
   a. Multiplying new income or increases in old income that the household received during the 3 months before the date of the evaluation by 4;
   b. Adding the product in subsection (D)(1)(a) to the annual income determined for the household at the last determination;
   c. Comparing the total amount in subsection (D)(1)(b) to the income limit for the household sizes under A.R.S. §§ 11-297, 36-2905, and 36-2905.03
2. If the total amount in subsection (D)(1)(c) is greater than the income limit, the county eligibility staff shall complete a redetermination under R9-22-1631.
3. If the total amount in subsection (D)(1)(c) is less than the income limit, the county eligibility staff shall evaluate the potential for the change to result in ineligibility before the end of the certification period.
4. If the county eligibility staff identifies a date before the end of the certification period when there will be a potential for ineligibility, the county eligibility staff shall evaluate the change again, at that time, under this subsection.

E. Changes in resources. If a household reports additional resources, the county eligibility staff shall evaluate the household's resources under R9-22-1627. If either the value of liquid resources or the net worth of all resources exceeds the limit prescribed by A.R.S. §§ 11-297, 36-2905, and 36-2905.03, the county eligibility staff shall send written notice of discontinuance of eligibility of all household members to the head-of-household.

F. Changes in alien status. The county eligibility staff shall evaluate the effect of a change in an MI/MN or ELIC member's alien status on the member's eligibility if a change is reported or if a household member's alien status expires.

1. The county eligibility staff shall verify the household member's United States citizenship or alien status following a change under R9-22-1624.
2. If the household member no longer meets the citizenship or alien status requirements under R9-22-1624, the county shall:
   a. Discontinue the member's MI/MN or ELIC coverage under this Article; and
   b. Determine whether the member is eligible for SESP under R9-22-1613;
      i. If the member is eligible, approve SESP coverage; or
      ii. If the member is ineligible, deny SESP coverage.

G. Changes in pregnancy status. If a MI/MN, ELIC, or SESP member reports that she is pregnant, the county eligibility staff shall either complete a redetermination of the pregnant member's household under R9-22-1631 or:
1. Explain the requirement to comply with the application process for eligibility under R9-22-1610;
2. Obtain the household member's signature on the statement of intent to cooperate;
3. Instruct the household member to apply at DES for S.O.B.R.A. or FES within 10 days and provide the address of where the household member can apply;
4. Discontinue MI/MN coverage if the household member does not apply within 10 days;
5. Discontinue MI/MN coverage if the household member applies but is denied for refusal to cooperate; and
6. Extend the household member's certification period under R9-22-1615 if the household member applies and is denied for a reason other than refusal to cooperate, and the household member provides verification of pregnancy to the county eligibility staff.

H. Changes in eligibility for household members. If a household member who is ineligible becomes eligible for MI/MN, ELIC, or SESP and another household member is already eligible for 1 of the programs, the county eligibility staff shall approve MI/MN, ELIC, or SESP coverage for the member who becomes eligible under this Article.

I. Changes based on county-to-county relocation.
1. If a head-of-household reports an address change to the county eligibility staff in the old county of residence, the county eligibility staff shall;
   a. Provide a copy of the most recent Part I Application,
   b. Instruct the head-of-household to report the address change to the county eligibility staff in the new county of residence, and
   c. Provide the address of that office to the head-of-household.
2. If an applicant or the head-of-household provides verification of address change to the county eligibility staff in the new county of residence:
   a. The head-of-household shall complete and sign a new Part I Application with updated data;
   b. The head-of-household shall provide a copy of the old Part I Application to the county eligibility staff in the new county;
   c. The county eligibility staff shall request a copy of Part I Application or the information contained in the Part I Application from the previous county of residence, if the applicant or head-of-household does not provide a copy of the Part I Application to the new county eligibility staff;
   d. The county eligibility staff shall compare the new Part I Application and the Part I Application filed with the previous county of residence. The county eligibility staff shall review other changes under this Article;
   e. The county eligibility staff in the new county of residence shall communicate a change:
      i. For a head-of-household, to the Administration, under R9-22-1618; and
      ii To the previous county of residence which shall send a copy of the head-of-household's AHCCCS case file to the new county of residence within 5 working days.

J. Interim changes occurring before determination. Except for changes in income and death of the head-of-household, if a change occurs before the date of determination, the county eligibility staff shall determine eligibility based on the changed information. If a household's income increases after the application date but before the date determination and the county eligibility staff approves eligibility, the county eligibility staff shall evaluate the effect of the increase in income on eligibility, under subsection (D).

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1631. MI/MN Redeterminations

A. Requested redetermination. A head-of-household may seek to obtain continued coverage for the household under this Article by submitting an application for redetermination to the eligibility staff in the household member's county of residence.
1. Within 60 days before the expiration of the certification period under R9-22-1615, or
2. If a household member becomes pregnant.

B. Required redetermination. Under R9-22-1630 the county eligibility staff shall complete a redetermination if an adult household member leaves the residence and household and if the departure of the applicant may result in ineligibility of the remaining household members due to excess income.

C. County responsibility. If a household member requests redetermination, the county eligibility staff shall:
1. If the redetermination was not requested by the head-of-household, inform the head-of-household or any other adult household member that a redetermination of eligibility is required;
2. Schedule a face-to-face interview.
   a. If the county eligibility staff is able to meet in-person with the head-of-household to schedule the interview, the county eligibility staff shall schedule a mutually agreeable appointment time and provide the head-of-household with written confirmation of the appointment time, unless the interview is conducted immediately.
   b. If the county eligibility staff is unable to meet in-person with the head-of-household, the county eligibility staff shall schedule an appointment time and notify the head-of-household of the time, by mail, within 3 working days. The member may request to change the appointment once if the request to change is made before the originally scheduled interview. The county eligibility staff shall then change the interview to mutually agreeable time.
   c. If the county eligibility staff does not receive acknowledgment of the scheduled interview from the head-of-household, the county eligibility staff shall make at least 1 additional attempt to notify the head-of-household of the scheduled appointment.
3. The county eligibility staff shall determine the household's eligibility under this Article.

D. Head-of-household responsibility. If applying for redetermination, the head-of-household has all rights and responsibilities as a head-of-household applying for eligibility under this Article.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1632. Reserved

R9-22-1633. Case Record for MI/MN Applications

A. General requirement. The county eligibility staff shall maintain a case record for every household that applies for MI/MN coverage.

B. Case record contents. The case record shall contain originals or copies of:
1. All documents that the county eligibility staff prepares or receives from the household regarding the application and determination of AHCCCS eligibility or ineligibility;
2. All documents regarding household members that the county eligibility staff receives from other sources;
3. Recordings of all information provided orally to the county eligibility staff by or regarding household members;
4. Recordings of all collateral verification the county eligibility staff obtains under R9-22-1622, including the identity and qualification of the party providing the verification and information being verified; and
5. Recordings identifying and explaining all actions the county eligibility staff takes regarding an application.

C. Required review. The county eligibility staff shall compare current information with a household's case record from prior applications to identify inconsistencies that may affect a new eligibility determination.

D. Retention of a case record. The county eligibility staff shall retain the case record for at least 3 years after date of the last entry or the date of a completed fraud investigation, whichever date occurs last.

E. Availability of the case record. The county eligibility staff shall make the case record available to the Administration or head-of-household upon written request.

F. Confidentiality. The county shall safeguard the case record and the information it contains under the requirements of R9-22-512.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1634. Eligibility Office Locations and Hours of Operation

A. County responsibility. Each county shall provide the Administration with a written list of the locations and hours of operation of county offices where a person may submit an application for MI/MN eligibility.

B. Administration responsibility. The Administration shall notify the counties of the hours of operation for the receipt of notification telephone calls made by the county under R9-22-1618.

C. Timeliness of notice. The notices in subsections (A) and (B) shall be provided no less than 5 days before the effective date of a change.

D. Frequency of notice. Parties shall provide notice under this Section at least 1 time annually.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1635. Reserved

R9-22-1636. Verification Review by the Director

At the discretion of the Director, the Administration shall review any county's applications, prior to notification of eligibility to the Administration under R9-22-1618, to ensure that the required verification and supporting case documentation are present.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

ARTICLE 17. ENROLLMENT

R9-22-1701. Enrollment of a Member with an AHCCCS Contractor

A. General Enrollment Requirements
1. The Administration shall not enroll an applicant with a contractor if an applicant:
   a. Resides in an area not served by a contractor;
   b. Is eligible for the Federal Emergency Services (FES) program as defined in R9-22-101 or the State Emergency Services Program defined in R9-22-1613;
   c. Is eligible for a period less than 30 days from the date the Administration receives notification of a member's eligibility, except for a member who is enrolled with CMDP or IHS as specified in this Section;
   d. Is eligible only for a prior quarter period as defined in R9-22-1432, except for a member who is enrolled with IHS as specified in this Section; or
   e. Is eligible only for a retroactive period of eligibility, except for a member who is enrolled with IHS as specified in this Section.
2. The Administration shall enroll a member with:
   a. A contractor serving the member's geographical service area (GSA) except as provided in subsection (C); or
   b. The member's most recent contractor of record, if available, if the member's period of ineligibility and disenrollment from the contractor of record is for a period of less than 90 days except if:
      i. The member no longer resides in the contractor's GSA,
      ii. The contractor's contract is suspended or terminated,
      iii. The member was previously enrolled with CMDP but at the time of re-enrollment the member is not a foster care child,
      iv. The member chooses another contractor during the annual enrollment choice period, or
      v. The member was previously enrolled with a contractor but at the time of re-enrollment the member is a foster care child.

B. Fee-for-service coverage. A member not enrolled with a contractor under subsection (A)(1) shall obtain covered medical services from an AHCCCS registered provider on a fee-for-service basis as provided in 9 A.A.C. 7.

C. Foster care child. The Administration shall enroll a member with CMDP if the member is a foster care child under A.R.S.§ 8-512.

D. Categorical, EAC, ELIC, and state alien member.
1. Except as provided in subsections (A)(1), (2)(b), and (C), a categorical, EAC, ELIC, or state alien member residing in an area served by more than 1 contractor shall have freedom of choice in the selection of an contractor.
2. A Native American member may select IHS or another available contractor.
3. If the member does not make a choice, the Administration shall auto-assign the member to:
   a. A contractor based on;
      i Family continuity, or
      ii The auto-assignment algorithm; or
   b. IHS, if the member is a Native American living on reservation.

E. MI/MN member.
1. A MI/MN member, including Native Americans, shall not receive freedom of choice in the selection of an AHCCCS contractor, except as specified in subsection (G).
2. Except as provided in subsection (A)(2)(b), the Administration shall auto-assign a member as specified in subsection (D)(3).

F. Family Planning Services Extension Program. A member eligible under the Family Planning Services Extension Program, as defined in R9-22-1435, shall remain enrolled with the member's contractor of record.

G. Enrollment changes for a member.
1. A member may change contractors during the annual enrollment choice period.
2. The Administration may approve the transfer for an enrolled member from 1 contractor to another as specified in 9 A.A.C. 5, or as determined by the Director.
3. The Administration shall approve a change in contractor for any member if the change is a result of a grievance, resolved through the grievance process specified in 9 A.A.C. 8.
4. A categorical, EAC, ELIC, or state alien member may choose a different contractor if the member moves into a GSA not served by the current contractor or if the contractor is no longer available. If the member does not select a contractor, the Administration shall auto-assign the member as provided in subsection (D)(3).
5. The Administration shall auto-assign an MI/MN member to a different contractor as specified in subsection (E)(2), if the member moves into a GSA not served by the member's current contractor.

H. Newborn enrollment. A newborn shall be initially enrolled with a contractor as specified in R9-22-1703.

I. IHS. The provisions of subsections (A)(1)(a), (2)(a), and (b)(iv), (D), (E), (F), (G), and (H) apply if IHS is the contractor.

J. CMDP. The provisions of subsections (A)(1)(d) and (e) and (H) apply if CMDP is the contractor.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1702. Effective Date of Enrollment with a Contractor and Notification to the Contractor

A. Effective date of enrollment. Except as otherwise specified in this Article, the Administration shall enroll the member with the contractor effective on the date enrollment action is taken by the Administration.

B. Financial liability of the contractor. Except for the prior quarter period as defined in R9-22-1432, the contractor shall be financially liable for an enrolled member's care as specified in contract.

C. Notice to contractor. The Administration shall notify the contractor of each member's enrollment with the contractor as specified in contract.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1703. Newborn Enrollment

A. General. A newborn child of an AHCCCS-eligible mother is initially enrolled with a contractor based on the mother's enrollment status.

B. Financial liability for all newborns. The contractor shall be financially liable for the medical care of the newborn as specified in the contract.

C. Notification to mother. The Administration shall notify the mother of the newborn's enrollment.

D. Choice. The Administration shall give the mother of the categorical newborn an opportunity to select a different contractor for the newborn. The mother of a noncategorical newborn shall not receive freedom of choice in the selection of a contractor.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-1704. Categorical and EAC Guaranteed Enrollment Period

A. General.
1. The Administration shall grant a guaranteed enrollment period as provided in this Section to a categorical or EAC member if the member meets the following conditions:
   a. Becomes ineligible before receiving 5 full calendar months of enrollment with a contractor as specified in 42 U.S.C. 1396a(e)(2),
   b. If the date of ineligibility does not precede or equal the date of initial enrollment,
   c. Did not receive 5 full calendar months of categorical enrollment during a previous categorically eligible period,
   d. Did not receive 5 full calendar months of EAC enrollment during a previous EAC eligible period, and
   e. Does not meet any of the conditions listed in subsection (B).
2. The member may receive a separate guaranteed enrollment:
   a. For a maximum of 1 time if the member is a categorical member, and
   b. For a maximum of 1 time if the member is an EAC.
3. The guaranteed enrollment period shall begin on the effective date of the member's initial enrollment with the contractor and shall continue for not less than 5 full calendar months.

B. Exceptions to guaranteed period. The Administration shall not grant a guaranteed enrollment period or shall terminate a guaranteed enrollment period as provided in subsection (C), if the member:
1. Is an inmate of a public institution as defined in 42 CFR 435.1009 except as provided in 9 A.A.C. 12,
2. Dies,
3. Moves out-of-state,
4. Voluntarily withdraws from the AHCCCS program,
5. Is adopted,
6. Is an EAC eligible and age 14, or
7. Is an EAC and fails or refuses to cooperate with the Title XIX eligibility process.

C. Disenrollment effective date. The Administration shall terminate any guaranteed enrollment period for which the member is not entitled effective on:
1. The date the member is admitted to a public institution specified in subsection (B), if known, or the date the Administration receives notification from the eligibility agency of the member's admission to a public institution;
2. The member's date of death;
3. The last day of the month in which the Administration receives notification from the eligibility agency that a member has moved out-of-state;
4. The date the Administration receives written notification of the member's voluntary withdrawal from the AHCCCS program;
5. The date adoption proceedings are initiated through a private party, if known, or on the last day of the month in which the Administration receives notification of the proceedings;
6. The last day of the month in which an EAC becomes age 14; or
7. The date the Administration receives notification from the eligibility agency that EAC eligibility will terminate

because the responsible member fails or refuses to cooperate with the Title XIX eligibility process.

D. Retroactive adjustments. The Administration shall adjust the member's eligibility and enrollment retroactively as specified in subsection (C).

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

TITLE 9. HEALTH SERVICES

CHAPTER 23. DEPARTMENT OF HEALTH SERVICES ORAL HEALTH

ARTICLE 1. GENERAL PROVISIONS

New Article 1, consisting of Sections R9-23-101 through R9-23-105, adopted effective February 23, 1993 (Supp. 93-1).

Former Article 1, consisting of Sections R9-23-111 through R9-23-121, repealed effective February 23, 1993 (Supp. 93-1).

Section
R9-23-101. Definitions
R9-23-102. Inspection of Premises
R9-23-103. Infectious Disease Control
R9-23-104. Required Dental Records
R9-23-105. Dispute Resolution
R9-23-106. Reserved
R9-23-107. Reserved
R9-23-108. Reserved
R9-23-109. Reserved
R9-23-110. Reserved
R9-23-111. Repealed
R9-23-112. Repealed
R9-23-113. Repealed
R9-23-114. Repealed
R9-23-115. Repealed
R9-23-116. Repealed
R9-23-117. Repealed
R9-23-118. Repealed
R9-23-119. Repealed
R9-23-120. Repealed
R9-23-121. Repealed

ARTICLE 2. STANDARDS FOR THE PROVISION OF ORAL HEALTH SERVICES

Article 2 heading amended effective September 12, 1996 (Supp. 96-3).

Article 2, consisting of Sections R9-23-201 through R9-23-203, adopted effective February 23, 1993 (Supp. 93-1).

Section
R9-23-201. Initial Nonemergency Visits
R9-23-202. Treatment Plan
R9-23-203. Full-mouth Radiographic Evaluations

ARTICLE 3. ORAL HEALTH SERVICES

Article 3 heading amended effective September 12, 1996 (Supp. 96-3).

Article 3, consisting of Sections R9-23-301 through R9-23-307, adopted effective February 23, 1993 (Supp. 93-1).

Section
R9-23-301. Scope of Services
R9-23-302. Eligibility
R9-23-303. Informed Consent
R9-23-304. Fluoride Mouth Rinse Program
R9-23-305. Dental Sealants Program
R9-23-306. Restorative Treatment Program
R9-23-307. Screening and Referral

ARTICLE 4. PREPAID DENTAL PLAN ORGANIZATIONS

Article 4, consisting of Sections R9-23-401 through R9-23-407, adopted effective February 23, 1993 (Supp. 93-1).

Section
R9-23-401. Program of Compliance
R9-23-402. Dental Care Plan
R9-23-403. Geographic Areas
R9-23-404. Chief Executive Officer
R9-23-405. Dental Director
R9-23-406. Dental Records
R9-23-407. Quality Improvement

ARTICLE 1. GENERAL PROVISIONS

R9-23-101. Definitions

In this Chapter, unless the context otherwise requires:

1. "Amalgam" means a combination of silver alloy and mercury used for dental restorations.
2. "Bitewing radiograph" means an x-ray film designed to show the crowns of the upper and lower posterior teeth simultaneously.
3. "Board eligible" means a dentist who has successfully completed an approved training program in a specialty field recognized by the American Dental Association.
4. "Caries" means areas of decay in or on a tooth.
5. "Chief executive officer" means the person who has the authority and responsibility for the operation of a prepaid dental plan organization in accordance with the applicable legal requirements and policies approved by the governing authority.
6. "Composite" means a mixture of a filler, usually quartz, ceramic, or glass particles, and a resin blend used for dental restorations.
7. "Contracting agency" means a governmental or nonprofit organization that has contracted with the OOH to provide clinical and/or administrative services.
8. "Copal base" means a liquid resin placed under a restoration to insulate the pulpal tissue.
9. "Dental facility" means a dental health clinic or institutional department staffed by licensed dentists or licensed dental hygienists, or both.
10. "Dental sealant" means a thin plastic coating applied to the chewing surfaces of premolar or molar teeth which fills the pits and grooves of a tooth and prevents the trapping of food debris.
11. "Dentate" means with teeth.
12. "Dentist" means a person who is licensed to practice dentistry under the provisions of A.R.S. § 32-1201 et seq.
13. "Dentition" means the type, number, and arrangement of teeth.
14. "Dentures" means a partial or complete set of false teeth designed to simulate the patient's natural dentition.
15. "Department" means the Department of Health Services.
16. "Diagnostic services" means those dental services necessary to identify dental abnormalities, including radiographs and clinical examinations.
17. "Director of an organized educational setting" means the person responsible for the overall management of the facility.
18. "Emergency services" means those dental services necessary to control bleeding, relieve pain, including local anesthesia, or eliminate acute infection. Medications that may be prescribed by the dentist, but must be obtained through a pharmacy, are excluded.

19. "Endodontics" means dental services related to the pulp of a tooth.
20. "Extraoral" means outside of the mouth.
21. "Fluoride" means a chemical compound, usually sodium fluoride or acidulated phosphate fluoride, applied topically or as a mouth rinse.
22. "General dentist" means a dentist licensed under the provisions of A.R.S. § 32-1201 et seq. whose practice is not limited to a specific area and who is not certified by a specialty board recognized by the American Dental Association.
23. "Gingival tissue" means intraoral soft tissue commonly referred to as the gums.
24. "Governing authority" means the person or body, including a board of trustees or board of directors, in whom the ultimate authority and responsibility for the direction of a prepaid dental plan organization is vested.
25. "Hamular notch" means the area behind the upper back molar.
26. "Hygienist" means a person who is licensed to practice dental hygiene under the provisions of A.R.S. § 32-1281 et seq.
27. "Intraoral" means inside the mouth.
28. "Mandibular" means associated with the lower jaw.
29. "Maxillary" means associated with the upper jaw.
30. "Mobile Dental Unit" or "MDU" means a self-contained dental operatory housed in a movable trailer owned by the Department.
31. "Mucobuccal fold" means the space between the cheek and teeth.
32. "Occlusion" means the manner in which the upper and lower teeth fit together when the mouth is completely closed.
33. "Office of Oral Health" or "OOH" means the office within the Department responsible for oral health services.
34. "Operative dentistry" means the use of dental amalgam, dental permanent cement, composite and noncomposite resin materials, cast alloy restorations, stainless steel and aluminum crowns, and various temporary and intermediate materials usually classified as cements to maintain a functional dentition.
35. "Operatory" means the patient chair and attached or related equipment used to deliver dental services.
36. "Organization" means a prepaid dental plan organization as defined in A.R.S. § 20-1001.
37. "Organized educational setting" means any facility providing supervised instructional care or services for children less than 21 years of age.
38. "Panographic radiograph" means an x-ray that shows all of the teeth and related structures on 1 film.
39. "Patient" means a person who is being attended by a dentist or dental hygienist to receive an examination, diagnosis, or dental treatment, or a combination of an examination, diagnosis, and dental treatment.
40. "Periapical" means a full view of an individual tooth, including the area under the gum line and around the root of the tooth.
41. "Portable dental equipment" means operatory equipment that can be transported by automobile and set up in a public area or private residence.
42. "Postdam" means a ridge built into a maxillary denture which touches the posterior soft tissue of the roof of the mouth.
43. "Posterior flange" means that part of a denture that extends into the space between the tongue and the mandibular jawbone or the cheek and maxillary jawbone.
44. "Preventive services" means dental care intended to maintain dental health and prevent dental disease, including any combination of oral hygiene education, professional prophylaxis, application of fluorides, and a viable system of recall or follow-up.
45. "Professional prophylaxis" means cleaning the teeth with mild abrasives and dental equipment.
46. "Pulpal" means the soft living tissue that fills the central cavity of a tooth.
47. "Radiograph" means a picture produced on a sensitive surface by a form of radiation other than light, including x-ray photographs.
48. "Representative sample" means a part of a population or subset from a set of units selected to investigate the properties of the population or the set.
49. "Restoration" means treatment that returns a patient to a functional level of dental health, including treatment of the pulpal tissues and gingival tissues, the use of metal and plastic fillings, and the use of removable partial and complete dentures.
50. "Saddle area" means that portion of a partial denture which covers the bone where posterior teeth from either the upper or lower jaw have been removed.
51. "Specialist" means a dentist whose practice is limited to a specified area and who is recognized by the appropriate specialty board of the Commission on Accreditation of Dental Education of the American Dental Association as board eligible or board certified.
52. "Therapeutic services" means basic dental services provided by a general dentist including pulp therapy for permanent and primary teeth exclusive of root canal therapy, restoration of carious permanent and primary teeth with materials other than cast restorations, and routine extractions.
53. "Treatment plan" means a statement of the services to be performed for the patient.

Historical Note

Adopted effective February 23, 1993 (Supp. 93-1).
Amended effective September 12, 1996 (Supp. 96-3).

R9-23-102. Inspection of Premises

A. OOH shall inquire into the provision of dental services monitored or funded by the Department by conducting, during regular business hours, inspections of all areas or matters affecting dental services to the public. The inspection shall include:
1. Interviewing the dentists who are employed by or own the dental facility,
2. Conducting a walk-through observation of the facility's infection control practices,
3. Auditing facility records, and
4. Providing oral and written feedback to the facility's dentists and staff.

B. Dentists shall comply with the *Guidelines for the Assessment of Clinical and Professional Performance*, 3rd Printing, 1992, California Dental Association, P.O. Box 13749, Sacramento, California 95853, which is incorporated by reference and on file with the Department and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

C. If OOH determines after an inspection that a dentist has failed to follow the *Guidelines for the Assessment of Clinical and Professional Performance*, 1992, and the failure constitutes a

threat to the public health, safety, or welfare, the Office shall report the findings to:

1. The owners or directors of the facility,
2. The Arizona Board of Dental Examiners with a recommendation for investigation of the facility's licensed professionals, and
3. The contracting agency with a recommendation for correcting the circumstances or canceling the facility's contract.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).
Amended effective September 12, 1996 (Supp. 96-3).

R9-23-103. Infectious Disease Control

All facilities providing professional dental services funded by the Department shall be maintained as follows:

1. Operatories shall be kept clean-swept and free from debris;
2. Counter surfaces of operatories, equipment used in patient care, and instruments used in extraoral examinations shall be disinfected after each patient with a solution comparable in disinfection ability to 1 part sodium hypochlorite and 10 parts water; and
3. Instruments used in intraoral examinations or treatment shall be disposed of or sterilized after each patient in compliance with 29 CFR 1910.1030, Occupational Exposure to Bloodborne Pathogens, July 1, 1992 which is incorporated by reference and on file with the Department and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).
Amended effective September 12, 1996 (Supp. 96-3).

R9-23-104. Required Dental Records

A. Each dental facility shall maintain a record of the symptoms presented, radiographs, diagnoses, treatment plans, and services provided to each patient of the facility.

B. Each dental record shall have displayed upon it the full name of the dentist responsible for the patient's treatment.

C. Original dental records shall be the property of the dental facility and shall not be removed from the premises except when a record or portion thereof:
1. Is subpoenaed by a court, or
2. Is being routed to other health professionals for consultation or evaluation.

D. Dental records shall be preserved in the original or by microfilm for 5 years, except when:
1. The patient is less than age 21, in which case the record shall be maintained for 3 years after the patient reaches age 21; or
2. The patient has received only preventive services, through OOH programs, in which case the record shall be maintained for 3 years.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).
Amended effective September 12, 1996 (Supp. 96-3).

R9-23-105. Dispute Resolution

If a dentist or dental facility funded or monitored by the Department pursuant to an agreement with another state agency that funds the dentist or dental facility wishes to protest audit or inspection findings; the dentist or dental facility shall file a written protest with the Chief of the OOH within 30 days of the protested action. The Chief of OOH shall acknowledge the protest in writing, within 15 working days of receipt, review the merits of the protest, and send written notice of the findings, conclusions, and decision to the protestor within 30 working days of the acknowledgment. The protestor may file an appeal, in writing, with the Department of Health Services, Director's Office, within 30 days of receipt of the decision, pursuant to R9-1-102 et seq.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).
Amended effective September 12, 1996 (Supp. 96-3).

R9-23-106. Reserved

R9-23-107. Reserved

R9-23-108. Reserved

R9-23-109. Reserved

R9-23-110. Reserved

R9-23-111. Repealed

Historical Note
Adopted effective June 21, 1978 (Supp. 78-3). Repealed effective February 23, 1993 (Supp. 93-1).

R9-23-112. Repealed

Historical Note
Adopted effective June 21, 1978 (Supp. 78-3). Repealed effective February 23, 1993 (Supp. 93-1).

R9-23-113. Repealed

Historical Note
Adopted effective June 21, 1978 (Supp. 78-3). Repealed effective February 23, 1993 (Supp. 93-1).

R9-23-114. Repealed

Historical Note
Adopted effective June 21, 1978 (Supp. 78-3). Repealed effective February 23, 1993 (Supp. 93-1).

R9-23-115. Repealed

Historical Note
Adopted effective June 21, 1978 (Supp. 78-3). Repealed effective February 23, 1993 (Supp. 93-1).

R9-23-116. Repealed

Historical Note
Adopted effective June 21, 1978 (Supp. 78-3). Repealed effective February 23, 1993 (Supp. 93-1).

R9-23-117. Repealed

Historical Note
Adopted effective June 21, 1978 (Supp. 78-3). Repealed effective February 23, 1993 (Supp. 93-1).

R9-23-118. Repealed

Historical Note
Adopted effective June 21, 1978 (Supp. 78-3). Repealed effective February 23, 1993 (Supp. 93-1).

R9-23-119. Repealed

Historical Note
Adopted effective June 21, 1978 (Supp. 78-3). Repealed effective February 23, 1993 (Supp. 93-1).

R9-23-120. Repealed

Historical Note
Adopted effective June 21, 1978 (Supp. 78-3). Repealed effective February 23, 1993 (Supp. 93-1).

R9-23-121. Repealed

Historical Note
Adopted effective June 21, 1978 (Supp. 78-3). Repealed effective February 23, 1993 (Supp. 93-1).

ARTICLE 2. STANDARDS FOR THE PROVISION OF ORAL HEALTH SERVICES

R9-23-201. Initial Nonemergency Visits

A. Dental services provided during initial nonemergency visits shall include an intraoral examination, two bitewing radiographs and a prophylaxis in dentate individuals. Initial visits for dentate children shall also include a topical fluoride application.

B. The dentist shall treat the patient after consideration of the results of the intraoral examination which reveals the existence of an infection or other dental emergency, the patient's complaint of pain and the desires of the patient.

C. The dentist shall develop a general medical history report which shall include:
1. The patient's general health and appearance, allergies and sensitivities to drugs, present medications and medical treatments, bleeding problems and nervous disorders; and
2. A clinical examination chart indicating the existence of caries, removable partial or complete dentures, the condition of pulpal tissues, restorations, missing teeth, the condition of gingival tissues and the general condition of the oral cavity.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).

R9-23-202. Treatment Plan

A. A treatment plan based upon medical histories, intraoral examinations and diagnoses shall be developed by a dentist for each patient and shall be designed to:
1. Relieve pain and discomfort;
2. Eliminate infection, irritations and traumatic conditions;
3. Provide professional prophylaxis and instruction in preventive practices;
4. Treat caries and pulpal inflammations;
5. Restore and replace teeth; or
6. Place the patient on a treatment schedule conducive to the maintenance of a functional dentition and the promotion of a healthy oral cavity.

B. Treatment plans specific to preventive care shall be based on an evaluation of the patient's occlusion, rate of plaque and calculus formation, susceptibility to caries, ability to practice preventive care and the general health of the patient's gingival tissue. The treatment plans shall provide for the following:
1. The restoration of broken or deformed teeth, a professional prophylaxis once a year, patient education on the control of plaque and the use of fluoride; and
2. The placement of sealants on newly erupted first and second molars and to previously erupted molars free of caries at the time of sealant application.

C. Restorative treatment plans shall be based on the nature and extent of the defect to be restored, the location of the defect in the tooth, the location of the tooth in the mouth, the stress distribution expected during mastication and aesthetic requirements. Treatment plans shall provide for the use of operative dentistry, removable partial dentures or complete dentures as follows:
1. During operative dentistry, the decision to use either a sedative base or a copal base shall be predicated on the vulnerability of the pulpal chamber to the cavity preparation and the type of restorative material used. Dental amalgam, dental permanent cement, and composite or noncomposite resin materials shall only be used in the following situations:
   a. Excessive masticatory force would not fracture the remaining tooth structure or restoration,
   b. Excessive abrasion of the restoration is not indicated,
   c. The restoration would be aesthetically acceptable, or
   d. One or more surfaces of a molar are to be restored.
2. Removable partial dentures shall be indicated as a treatment procedure when the teeth in question have been removed. Partial dentures may be entirely tooth supported or tooth and tissue supported and shall be:
   a. Constructed of materials which resist bending or breakage during normal function and are aesthetically pleasing, color stable, nonporous, nontoxic and nonabrasive to the opposing or supporting dentition; and
   b. Designed to facilitate oral hygiene and health and provide for:
      i. Satisfactory saddle area coverage, functional stability, noninterfering functional occlusion and passive retention when not in function; and
      ii. Increased masticatory function for the patient.
3. Complete dentures shall be indicated when all of the upper and/or lower teeth have been removed. The dentures shall be:
   a. Constructed of materials which resist bending or breakage during normal function and are aesthetically pleasing, color stable, nonporous, nontoxic and nonabrasive to oral soft tissue; and
   b. Designed according to the following specifications:
      i. Complete dentures shall exhibit proper peripheral seal at the mucobuccal fold and cover those areas of the arch that provide maximum support and remain seated when normal biting pressure is applied in the posterior and anterior segments of the arch and during talking and smiling.
      ii. The maxillary denture shall cover the entire hard palate with the postdam, achieve a posterior seal on the soft palate extending from hamular notch to hamular notch, and achieve stability without evidence of inflammation or ulceration of the oral soft tissue.
      iii. The mandibular denture shall have full posterior flanges extending to or beyond the floor of the mouth sufficiently to include a portion or all of the pad behind the rear molar, adapt closely to the soft tissues, and achieve stability without evidence of inflammation or ulceration.
4. A dentist advising a patient regarding dentures shall inform the patient of the necessity for modifying dentures

at periodic intervals to compensate for tissue changes that may occur.

D. The continuation of any treatment plan shall be predicated upon the written informed consent of the patient, or the parent or legal guardian of the patient, in accordance with R9-23-303. A treatment plan involving extractions or surgical procedures shall require an additional written informed consent prior to providing the services and specific to the procedures proposed.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).

R9-23-203. Full-mouth Radiographic Evaluations

A. Each patient shall undergo a full mouth radiographic evaluation once every three years unless there are specific indications for more frequent examinations. Evaluations shall be tailored to the needs and age of the patient in accordance with the following guidelines:
1. Evaluations of children, prior to the eruption of the .permanent second molars,.shall include those periapical and bitewing or panographic views or lateral jaw views that will depict the erupted and developing dentition.
2. Evaluations of adults shall include those periapical and bitewing views or a panographic view as needed to depict the current dentition and its support.

B. Nonemergent radiographs shall be avoided when possible for patients in the first trimester of pregnancy.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).

ARTICLE 3. ORAL HEALTH SERVICES

R9-23-301. Scope of Services

A. Services delivered under OOH shall be provided directly by the Department or through contracted facilities, agencies or individuals. The following services shall be provided:
1. Fluoride mouth rinse programs as provided for in R9-23-304,
2. Dental sealant programs as provided for in R9-23-305,
3. Restorative treatment as provided for in R9-23-306, and
4. Screening and referral to the private dental sector as provided for in R9-23-307.

B. Nothing in this Article shall be construed to establish an entitlement program. The provision of services by the Office of Oral Health is contingent on available funding.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).
Amended effective September 12, 1996 (Supp. 96-3).

R9-23-302. Eligibility

The following individuals shall be eligible for dental health services:
1. Children who are eligible for the federal free or reduced school lunch program;
2. Persons who are eligible for federal, state, or a combination of federal and state nutrition programs; or
3. Persons whose income is at or below 133% of the federal poverty guideline or who are eligible Medicaid recipients but:
   a. Do not have access to dental care, or
   b. Whose physical or mental impairment precludes them from receiving dental services through the private dental sector.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).

R9-23-303. Informed Consent

A. For each patient, a dental facility shall have on file a consent form provided by OOH that includes the following information:
1. Name, address, and telephone number of the patient;
2. Name, address, and telephone number of the physician to contact in the event of a medical problem with the patient;
3. Age of the patient;
4. The physical or mental impairment, if any, which precludes the patient from authorizing the patient's own treatment; and
5. The signature of the patient, or parent or legal guardian of the patient, and the date of the signature.

B. A dental facility shall obtain a new consent form for each patient at the beginning of each new treatment plan or each year after the initial form.

C. The patient, or parent or legal guardian of the patient, may cancel the consent form at any time by submitting a signed and dated letter of cancellation to OOH.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).
Amended effective September 12, 1996 (Supp. 96-3).

R9-23-304. Fluoride Mouth Rinse Program

A. OOH shall provide education and instruction on the methods and benefits of rinsing the mouth with a prepared solution of sodium fluoride on a weekly basis to children, their parents or legal guardians, instructors, school nurses, or any other supervisory representatives at the request of the director of an organized educational setting. The education and instruction shall include techniques for the safe storage of fluoride.

B. The director of the organized educational setting shall designate a representative to supervise the program and maintain contact with OOH to facilitate the ordering of fluoride mouth rinse supplies from the OOH.

C. Designated employees of the organized educational setting shall provide the fluoride mouth rinse to, and supervise its use, by participating children.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).
Amended effective September 12, 1996 (Supp. 96-3).

R9-23-305. Dental Sealants Program

A. OOH shall provide education on the benefits of applying a dental sealant to the chewing surface of newly erupted molars to children eligible pursuant to R9-23-302, their parents or guardians, instructors, school nurses, or other designated representatives at the written request of the director of an organized educational setting.

B. A dentist representing OOH or under contract with OOH shall screen eligible children to determine if each child's molars are:
1. Sufficiently erupted to allow treatment,
2. Free from decay, and
3. Free from prior restorations.

C. OOH shall schedule eligible children for the application of sealants by a dentist or hygienist.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).
Amended effective September 12, 1996 (Supp. 96-3).

R9-23-306. Restorative Treatment Program

A. OOH shall provide restorative treatment services to patients eligible pursuant to R9-23-302 based on their condition and within the capabilities of an MDU or OOH's portable equip-

ment, at the written request of the patient or the patient's parent or legal guardian.

B. Patients in need of restorative treatment services beyond those provided by an MDU or OOH's portable equipment shall be referred by OOH to the private dental sector. The cost of any treatment provided by the private dental sector shall be the responsibility of the patient, or parent or legal guardian of the patient.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).
Amended effective September 12, 1996 (Supp. 96-3).

R9-23-307. Screening and Referral

A. At the request of patient eligible pursuant to R9-23-202, or parent or legal guardian of the patient, OOH shall schedule a screening examination to evaluate the patient's oral health status with the dental health professional representing OOH in the patient's geographic area.

B. When a screening examination reveals the need for dental treatment, the dental health professional shall refer the patient either to another dental health professional representing OOH or to the private dental sector.
1. Referrals to the private dental sector shall be based upon special needs of the patient that OOH cannot provide.
2. The cost of any treatment provided by the private dental sector shall be the responsibility of the patient or parent or legal guardian of the patient.

C. When referring a child or a person requiring a legal guardian, the dental health professional shall provide to the patient, parent, or legal guardian, a completed referral form furnished by OOH outlining the nature of the problems discovered in the screening examination.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).
Amended effective September 12, 1996 (Supp. 96-3).

ARTICLE 4. PREPAID DENTAL PLAN ORGANIZATIONS

R9-23-401. Program of Compliance

A. Any organization submitting an application for a certificate of authority to the Department of Insurance, as prescribed by A.R.S. § 20-1002, shall, at the same time, submit to the Department a written program of compliance that specifies how the organization will comply with the provisions of this Article. The written program of compliance shall contain descriptions of the following:
1. The organization's dental care plan including the proposed or actual:
   a. Enrollment, both member and dependent;
   b. Professional staffing, identifying board eligibility or certification, for each dentist and hygienist listed;
   c. Dental support staff by number and classification; and
   d. Provisions for using consultants for dental services that cannot be provided by the organization's staff.
2. The organization's geographic areas, including maps indicating the boundaries of the proposed geographic areas and the locations of all facilities in which dental care will be provided under the plan.
3. The responsibilities and qualifications of the following positions:
   a. The organization's chief executive officer, and
   b. The organization's dental director.
4. The organization's dental record system.
5. The organization's quality improvement program.

B. Within 45 days of receipt of the written program of compliance by the Department, the Director shall make a written finding whether the program complies with the requirements of this Article and shall notify the Department of Insurance and the organization of this finding.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).
Amended effective September 12, 1996 (Supp. 96-3).

R9-23-402. Dental Care Plan

A. Dental care plans shall include the following basic dental services which shall be set forth in the evidence of coverage:
1. Emergency services on a 24-hour-per-day basis,
2. Diagnostic services,
3. Preventive services, and
4. Therapeutic services.

B. Each plan shall have an organized system for the delivery of services set forth in subsection (A). The delivery system:
1. Shall include general dentists, a procedure which promotes a continuing relationship between a member and the member's general dentist, and a procedure for effective referrals to assure continuity of care to members; and
2. May include specialists, registered dental hygienists and other dental professionals.

C. All care provided by the organization shall be by licensed dental health professionals. Services provided on a continuing basis by other than organization employees shall be covered by written service agreements.

D. Emergency services obtained by any member, provided by a licensed dental health professional, shall be paid for by the organization regardless of the location of the facility providing the services. This includes emergencies which occur within the area served by the member's designated provider but the provider is unavailable, or when the emergencies occur outside of the member's designated service area.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).
Amended effective October 27, 1994 (Supp. 94-4).

R9-23-403. Geographic Areas

A. Each organization shall designate geographic areas in which it has the capability of providing services that are reasonably convenient to the prospective members. The organization shall provide a description of the geographic areas and locations of all facilities in which dental care will be provided under the prepaid dental plan. This information shall accompany any advertisements or sales materials provided to prospective enrollees.

B. Each organization shall define its geographic areas by citing one of the following:
1. Legal description;
2. Local government jurisdictions including cities, counties, etc.;
3. Census tracts;
4. Street boundaries; or
5. Area within a specified radius of an intersection or dental care center.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).

R9-23-404. Chief Executive Officer

A. The governing authority shall appoint a chief executive officer who has the education and/or experience to manage the organization.

B. The chief executive officer shall be based at a central place of business within the organization's major geographic area and shall be responsible for:
1. Implementing the policies of the governing authority;
2. Serving as a liaison between the governing authority, providers of dental care and providers of other services for the organization; and
3. Establishing a line of authority during periods of the officer's absence.

C. The governing authority shall notify the Department and the Department of Insurance within ten days after the effective date of a change in the appointment of the chief executive officer.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).

R9-23-405. Dental Director

A. The governing authority shall designate a dentist as dental director who may also serve as the chief executive officer.

B. The dental director shall be responsible for developing dental care policies, coordinating the activities of the dental staff and supervising the dental staff, which shall include the performance planning and evaluation of the staff.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).

R9-23-406. Dental Records

A. The organization shall assure that a dental record is maintained for each member.

B. The dental record shall be maintained at the designated provider facility in accordance with acceptable professional standards pursuant to *Guidelines for the Assessment of Clinical and Professional Performance*, 1992 as amended, and shall include the following:
1. The full name of the dentist responsible for the treatment,
2. A record of the symptoms presented,
3. Radiographs,
4. Diagnosis,
5. Treatment plans, and
6. Services provided to each member of the organization by its employees or contractors.

C. Dental records shall be the property of the organization's provider groups and shall not be removed from the provider's premises except when subpoenaed by a court or for the routing of the record, or portion thereof, to dental or medical practitioners for consultation or evaluation.

D. The Department shall have access to the dental records of the organization's provider groups for review under the following circumstances:
1. During routine surveys, a representative sample of dental records of members of the organization shall be reviewed.
2. For complaints or special investigations, dental records pertaining to the complaint or investigation shall be reviewed.

E. The organization shall furnish, within 30 days after a member's requested release from membership coverage and upon the member's request, a written summary covering all phases of dental care provided during enrollment including copies of reports and results of diagnostic tests. Copies of radiographs shall be forwarded to a member's new dentist if requested by the dentist. The costs of providing this service may be charged to the member.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).

R9-23-407. Quality Improvement

A. The governing authority shall appoint a quality improvement committee, which shall meet at least annually, consisting of the chief executive officer or designee, the dental director, dental health professionals, allied health professionals, and consumers who are members of the plan.

B. The quality improvement committee shall establish dental care standards equivalent to *Guidelines for the Assessment of Clinical and Professional Performance*, 1992, review and evaluate services performed by the organization's dental health professionals, and adopt administrative procedures covering frequency of meetings, types of records to be kept, and arrangements to produce and distribute committee reports.

C. A copy of the minutes of each quality improvement committee meeting shall be forwarded to the Director, Department of Health Services.

D. Each organization shall maintain a quality improvement plan that includes procedures to be used for each of the following:
1. Compliance with the standards for dental care as established in subsection (B),
2. Surveillance of care provided,
3. Analysis of problems identified,
4. Correction of deficiencies including a time schedule for correction, and
5. Periodic reassessment of the plan.

E. The organization shall maintain a written program of compliance that contains annually updated information as specified in R9-23-401(A)(1) through (5) and is subject to review by the Department.

Historical Note
Adopted effective February 23, 1993 (Supp. 93-1).
Amended effective September 12, 1996 (Supp. 96-3).

TITLE 9. HEALTH SERVICES

CHAPTER 24. DEPARTMENT OF HEALTH SERVICES MEDICALLY UNDERSERVED AREA MEDICAL SERVICES

ARTICLE 1. GENERAL

Section
R9-24-101. Reserved
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R9-24-103. Reserved
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R9-24-105. Reserved
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R9-24-111. Legal Authority
R9-24-112. Designation
R9-24-113. Definitions

ARTICLE 2. CRITERIA

Article 2 consisting of Sections R9-24-201 through R9-24-205 recodified from R9-24-121 through R9-24-130 (Supp. 95-2).

Section
R9-24-201. Geographic Units
R9-24-202. Out-of-state Resources
R9-24-203. Base Criteria
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Article 3 consisting of Section R9-24-301 recodified from Sections R9-24-131 through R9-24-140 (Supp. 95-2).

Section
R9-24-301. Functions

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Article 4, consisting of Sections R9-24-401 through R9-24-412, adopted effective March 17, 1995 (Supp. 95-2).

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R9-24-402. Service Site Eligibility
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R9-24-404. Annual Loan Repayment Award Cycle
R9-24-405. Site Vacancy Register Eligibility
Exhibit A. Notification of Vacancy for Participation in Arizona Loan Repayment Program (ALRP)
R9-24-406. Ranking of Eligible Sites
R9-24-407. Applicant Eligibility Criteria
R9-24-408. Application and Selection of Program Participants
Exhibit B. Health Professional Application
R9-24-409. Loans Qualifying for Repayment
R9-24-410. Allowable Award Amounts
R9-24-411. Contracting Process
Exhibit C. Arizona Loan Repayment Program Contract
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Exhibit D. Service Verification Form

ARTICLE 1. GENERAL

R9-24-101. Reserved
R9-24-102. Reserved
R9-24-103. Reserved
R9-24-104. Reserved
R9-24-105. Reserved
R9-24-106. Reserved
R9-24-107. Reserved
R9-24-108. Reserved
R9-24-109. Reserved
R9-24-110. Reserved

R9-24-111. Legal Authority

The Arizona Department of Health Services, pursuant to the authority granted in Title 36, Chapter 24, particularly A.R.S. § 36-2352 and 36-2353, hereby adopts the Regulations in this Chapter.

Historical Note
Adopted effective July 27, 1978 (Supp. 78-4).

R9-24-112. Designation

Pursuant to A.R.S. § 36-2352, the Department shall periodically designate medically-underserved areas as part of the State Health Plan. Such designations shall be made in conjunction with authorized local agencies as defined in A.R.S. § 36-401, or their successor organizations. The Director, as empowered by A.R.S. § 36-124, may confer and cooperate with any or all other persons, organizations, or government agencies that have an interest in public health problems and needs in preparing and administering the State Health Plan, including the designation of medically-underserved areas.

Historical Note
Adopted effective July 27, 1978 (Supp. 78-4).

R9-24-113. Definitions

In Articles 1, 2 and 3 of this Chapter, unless the context otherwise requires:

1. "Clinical laboratory" means a laboratory licensed pursuant to Title 36, Chapter 4.1, a laboratory of a hospital licensed by the State, or a laboratory which is operated by the Federal government.
2. "Civilian population" means the total resident population excluding active duty military personnel. Dependents of active duty military personnel are included in the civilian population.
3. "Coordinating medical provider" means a physician or group of physicians, or any combination thereof which has entered into an agreement with a county, incorporated city or town, health service district or the Department to supervise the medical care offered at a medical clinic.
4. "Current" means most recently available data.
5. "Direction" means authoritative policy or procedural guidance for the accomplishment of a function or activity.
6. "Director" means Director of the Department of Health Services.
7. "Full time equivalent primary care physician" means a primary care physician who spends at least 40 hours per week providing direct patient care or services, including related administrative duties, diagnosis and treatment and training provided to interns, residents, nurse practitioners, physician assistants, students and trainees while providing direct patient care and services. Each nurse practitioner or physician assistant providing at least 40 hours per week of direct patient care is considered equal to .5 full time equivalent primary care physician.

8. "General hospital" means a hospital which provides inpatient services, diagnostic and therapeutic, for a wide variety of medical conditions, both surgical and nonsurgical.
9. "Governing board" means the board of directors of health service district to be established pursuant to A.R.S. § 36-2368.
10. "Hospital" means a health care institution licensed as a hospital pursuant to Title 36, Chapter 4, or an institution performing similar functions which is operated by the Federal government.
11. "Infant death" means the death of a live-born infant prior to the age of one year.
12. "Medical clinic" means a facility, whether mobile or stationary, which provides ambulatory medical care in a medically-underserved area through the employment of physicians, nurses, physicians' assistants, nurse practitioners or other health care technical and paraprofessional personnel.
13. "Nurse practitioner" means a registered nurse certified by the Arizona State Board of Nursing to function in the extended role pursuant to Title 32, Chapter 15.
14. "Pharmacist" means a person registered as a pharmacist pursuant to Title 32, Chapter 18, or a person practicing as a pharmacist in a Federal health care institution.
15. "Pharmacy" means an establishment where prescription orders are compounded and dispensed by or under the direct supervision of a registered pharmacist and which is registered pursuant to Title 32, Chapter 18, or which performs similar functions as a Federally operated facility.
16. "Physician" means a person licensed pursuant to Title 32, Chapter 13 or 17, and shall include nonresident practitioners holding area permits pursuant to A.R.S. §§ 32-1426.01 or 32-1823.02, or a person practicing as a physician in a Federal institution.
17. "Physician assistant" means any person certified by the Joint Board of Medical Examiners and Osteopathic Examiners in Medicine and Surgery as a physician's assistant.
18. "Premature birth" means the live birth of an infant weighing 2500 grams (5-1/2 pounds) or less at birth.
19. "Primary care physician" means a general practitioner, family practitioner, internist, obstetrician, obstetrician-gynecologist, or pediatrician.
20. "Registered nurse" means a person licensed pursuant to Title 32, Chapter 15, or a person practicing as a registered nurse in a Federal health care institution.
21. "Supervision" means direct overseeing and inspection of the act of accomplishing a function or activity.
22. "Visit" means a physician-patient encounter involving direct service to the patient excluding phone visits.

Historical Note
Adopted effective July 27, 1978 (Supp. 78-4).

ARTICLE 2. CRITERIA

R9-24-201. Geographic Units

A. Geographic units in this Section apply to R9-24-203, Base Criteria, and R9-24-204, Supplementary Criteria, for the purpose of designating medically-underserved areas. The geographic units are the Fort Apache, Hopi, Navajo, Papago and San Carlos Indian reservations and each of the counties, with the following modifications:
1. County boundaries are modified to exclude areas within the five Indian reservations listed above.
2. Each of the Indian reservations listed above will be considered for designation in its entirety except the Navajo. The Navajo Reservation shall be divided along county lines, and each of the three resulting areas shall be considered individually for designation.
3. The Hopi-Navajo Joint Use Area is included in the Navajo Reservation and excluded from the Hopi Reservation.
4. The Gila Bend Indian Reservation in Maricopa County is included in the Papago Reservation and excluded from Maricopa County.
5. The Gila River Indian Reservation in Maricopa County, Census Tract 6232, is included with Pinal County and excluded from Maricopa County.

B. For counties other than Pima and Maricopa, the only areas to be considered for designation are entire counties, modified along Indian reservation lines as described above, minus each community or group of closely located communities which have civilian populations of 5,000 or more and which have 100 percent or more of their estimated demand met for primary care physicians.

C. The following groups of 1970 U.S. Census Tracts in Maricopa County are considered separately for designation:
1. Census Tracts 405, the Wickenburg Division.
2. Census Tracts 506 and 507, the Buckeye Division.
3. Census Tract 7233, the Gila Bend Division, less the Indian reservation areas allocated to the Papago.
4. Census Tracts 608-614, 715-719, 820-822 and 923-931, Sun City, Luke Air Force Base, Avondale, and vicinity.
5. Census Tracts 303, 1036-1047 and 1052-1063, north central Maricopa County, including portions of north Phoenix.
6. Census Tracts 101, 202, 304, 1032-1035, 1048-1051, 1079-1083, 1110-1113, 1137, 2168-2183 and 3184-3186, northeastern Maricopa County, including Scottsdale and portions of northeast Phoenix.
7. Census Tracts 1068-1073, 1090-1103, 1120-1128 and 1144-1147, the west Phoenix and Glendale area.
8. Census Tracts 1064-1067, 1074-1078, 1084-1089, 1104-1109, 1114-1119, 1129-1136, 1138-1143 and 1148-1151, central Phoenix.
9. Census Tracts 1152-1167, south Phoenix and vicinity.
10. Census Tracts 3187-3200, Tempe and vicinity.
11. Census Tracts 4201-4226 and 5227-5231, southeast Maricopa County, including Mesa.

D. In addition to the Papago Reservation, the following groups of 1975 U.S. Census Tracts in Pima County are considered separately for designation:
1. Census Tracts 4403-4405, the Marana Division.
2. Census Tracts 4603-4606 and 4705-4707, the Catalina Division.
3. Census Tracts 4016-4019, the Tanque Verde Division.
4. Census Tract 4102, the Benson Highway Division.
5. Census Tracts 4302 and 4303, the Arivaca Division.
6. Census Tracts 4900 and 5000, western Pima County, including Ajo.
7. The balance of the county, representing the Tucson metropolitan area.

Historical Note
Adopted effective July 27, 1978 (Supp. 78-4). R9-24-201 recodified from R9-24-121 (Supp. 95-2).

R9-24-202. Out-of-state Resources

In designating medically-underserved areas, the Department may take into account resources located outside the State which are accessible to Arizona residents and which fall within the limits established by individual criteria and standards described in R9-24-203 and R9-24-204.

Historical Note

Adopted effective July 27, 1978 (Supp. 78-4). R9-24-202 recodified from R9-24-122 (Supp. 95-2).

R9-24-203. Base Criteria

A. All areas are considered for designation first on the basis of percent-demand-met for primary care physicians.

B. An area having 85 percent or less of its estimated demand met for primary care physicians shall be designated as medically-underserved by the Department.

C. The method utilized to determine percent-demand-met is as follows:

1. Data required.
   a. Population subgroups - age by sex civilian population breakdown for each area to be considered.
   b. Subgroup utilization rates - age by sex breakdown for average annual visits to all physicians.
   c. Percent primary care visits - percent of total visits made to primary care physicians.
   d. Primary care physician productivity - average annual number of visits per full time equivalent primary care physician.
   e. Primary care physicians - total full time equivalents for each area to be considered. The Department may take into account local information regarding practices restricted to specific population subgroups, age and health status of physicians, stated intent of local physicians regarding expansion or reduction of practices, and other relevant factors when computing the full time equivalent primary care physician total for each area.
2. Computation of percent-demand-met.
   a. Compute total visits for the area's population. Multiply each population subgroup in the area by the subgroup utilization rate. Add the age/sex specific products to obtain total visits for the area.
      i. Total Visits = Sum of (Population Subgroup x Subgroup Utilization Rate).
   b. Compute primary care visits for the area's population. Multiply total visits by percent primary care visits.
      i. Primary Care Visits = Total Visits x Percent Primary Care Visits.
   c. Compute demand for full time equivalent primary care physicians. Divide primary care visits by primary care physician productivity.
      i. Demand Primary Care Visits/Primary Care Physician Productivity.
   d. Compute percent-demand-met for primary care physicians. Divide total full time equivalent primary care physicians for the area by demand, and multiply times 100.
      i. Percent-Demand-Met = (Primary Care Physicians/Demand) x 100.

Historical Note

Adopted effective July 27, 1978 (Supp. 78-4). R9-24-203 recodified from R9-24-123 (Supp. 95-2).

R9-24-204. Supplementary Criteria

A. Areas which do not meet the primary care physician percent-demand-met standard described in R9-24-123 but which obtain percent-demand-met scores from 86 percent through 99 percent shall be designated if they qualify according to the supplementary criteria described in this Section. Supplementary criteria are to be used solely for the purpose of designating medically-underserved areas; they do not constitute standards for evaluating the delivery of medical services.

B. An area eligible for consideration for designation according to the supplementary criteria shall be designated medically-underserved by the Department if it obtains a score of 6 points or more. Scores are determined by assigning points to the area for qualifying according to specific criteria. Points to be assigned are listed below:

POINTS	CRITERIA
2	Infant Mortality Rate
2	Accidental Death Rate
2	Motor Vehicle Accident Rate (involving injury or death)
2	Emergency Services
2	Emergency Transportation
1	Premature Birth Rate
1	Availability of Pharmacists and/or Pharmacy Services
1	Availability of Nurses
1	Availability of Hospital Facilities
1	Availability of Clinical Laboratory Services
1	Scheduled, Routine Patient Transportation Services

C. Definitions, standards and method of determination for the eleven supplementary criteria follow:

1. "Infant mortality rate".
   a. An area having an infant mortality rate greater than the current state or national rate, whichever is less, shall receive two points toward designation.
   b. Computation of infant mortality rate.
      i. Infant mortality rate = (Infant deaths/live births) x 1000.
      ii. Infant deaths and live births in the above equation are composed of data from the most recent five years for which both infant death and live birth information are available by place of residence.
      iii. The infant mortality rate is computed to the nearest tenth.
      iv. Infant mortality rates shall be computed for each Indian reservation area to be considered for separate designation, and for counties modified by Indian reservation boundaries. Rates for subareas within Maricopa and Pima Counties shall be the county rates except when the numbers of infant deaths and live births in subareas are sufficiently large that the addition of five infant mortality rate no greater then 5 percent.
2. "Accidental death rate".
   a. An area having an accidental death rate greater than the current state or national rate, whichever is less, shall receive two points toward designation.
   b. Computation of accidental death rate.
      i. Accidental death rate = (Accidental deaths/total population) x 100,000.
      ii. Accidental deaths shall be aggregated by location of accident, not by residence of deceased.
      iii. The accidental death rate is computed to the nearest tenth.
      iv. Accidental deaths in the above equation are composed of data from the most recent five years for which both accidental death and total population data are available.
      v. Because of data availability, rates may be computed only for counties and counties minus any of the following twelve communities which may be in that county: Kingman, Glendale,

Phoenix, Mesa, Scottsdale, Tempe, Tucson, Flagstaff, Yuma, Douglas, Prescott and Chandler.

vi. Rates for counties modified by reservation boundaries shall be the county rate computed after removing data for any of the twelve communities which have 100 percent or more of their demand met for primary care physicians. Rates for Indian reservations shall be an aggregation of county rates minus all communities' rates for those counties in which the reservation is located. The county rates shall be aggregated by weighting each county rate by the proportion of the total reservation population which resides in the county.

3. "Rates for motor vehicle accidents involving injury or death".
   a. An area having a motor vehicle accident rate involving either injury or death greater than the current state or national rate, whichever is less, shall receive two points toward designation.
   b. Computation of motor vehicle accident rate.
      i. Using the following formula, two separate rates are computed: one for accidents involving injury, and the other for accidents involving death. Vehicle miles shall be identical for both computations.
      ii. Rate = (Motor vehicle accidents/vehicle miles) x 100 million.
      iii. Motor vehicle accidents in the above equation are composed of data from the most recent two years for which motor vehicle accidents involving injury, motor vehicle accidents involving death and vehicle mile data from each area are available.
      iv. The motor vehicle accident rate is computed to the nearest tenth.
      v. Because motor vehicle mile data are currently available only for counties, rates for counties modified by reservation boundaries shall be the county rates. Rates for Indian reservations shall be computed by aggregating the county rates for those counties in which the reservation is located and weighting each county rate by the proportion of the reservation population residing in that county.
4. "Emergency services".
   a. An area whose center of population is greater than 20 miles from the closest emergency services available on call shall receive two points towards designation.
   b. For purposes of this criterion, emergency services include, but are not limited to, hospital emergency rooms, outpatient centers, police and fire rescue units, ambulances staffed by emergency personnel, and primary care physician, nurse practitioner or physician assistant offices, if these services are available on call and provided to the general public.
5. "Emergency transportation".
   a. An area whose center of population is greater then 35 miles from the closest source of emergency transportation available on a 24-hour per day basis shall receive two points towards designation.
   b. For purposes of this criterion, emergency transportation includes, but is not limited to, ambulances staffed by trained emergency personnel, police and fire department rescue units and air evacuation services if available on a 24-hour per day basis and provided to the general public.
6. "Premature birth rate".
   a. An area having a premature birth rate greater than the current state or national rate, whichever is less, shall receive one point towards designation.
   b. Computation of premature birth rate.
      i. Premature birth rate = (Premature births/live births) x 1000.
      ii. Premature births in the above equation are composed of data from the most recent five years for which both premature birth and live birth data are available by mothers' place of residence.
      iii. The premature birth rate is computed to the nearest tenth.
      iv. Premature birth rates shall be computed for each major Indian reservation and county modified by an Indian reservation. Rates for subareas within Maricopa and Pima Counties shall be the county or reservation rates, except when the number of premature births and live births in the subarea are sufficiently large that the addition of five premature births to the sum of premature births produces a change in the premature birth rate no greater than 5 percent.
7. "Availability of pharmacists and/or pharmacy services".
   a. For purposes of this criterion, an urban area shall be defined as any of those areas listed under R9-24-121, Subsection C. Paragraphs 4-11 and Subsection D. Paragraph 7, and a rural area shall be defined as any other geographic area listed under R9-24-121.
   b. An urban area whose center of population is greater than five miles from the closest active pharmacist or pharmacy services provided to the general public during regular business hours shall receive one point towards designation.
   c. A rural area containing any community of 5,000 or more population, which community's center of population is greater than five miles from the closest active pharmacist or pharmacy services provided to the general public during regular business hours, shall receive one point towards designation. For rural areas containing no community of 5,000 or more the five mile standard shall be applied to the largest community within the area.
8. "Availability of registered nurses". An area which contains any location currently listed as a "Shortage Area Designated for Repayment for Service as a Registered Nurse" by the Federal government (42 CFR Part 57, Subpart D, and revisions) shall receive one point towards designation.
9. "Availability of general hospitals". An area whose center of population is greater than 55 miles from the nearest general hospital which provides emergency services to the general public shall receive one point towards designation.
10. "Availability of clinical laboratories". An area whose center of population is greater than 75 miles from the nearest clinical laboratory shall receive one point towards designation.
11. "Scheduled, routine patient transportation services".
    a. An area which does not have available to it scheduled, routine patient transportation services at least

twice weekly shall receive one point towards designation.

b. For purposes of this criterion, scheduled, routine patient transportation services includes any public or private transportation except taxi service which the general public may use for nonemergency travel to and from health care facilities within a 16-hour period. Transportation services provided by volunteer groups are included if their services are provided to all members of the general public who have no other means of travel to health facilities available to them.

Historical Note
Adopted effective July 27, 1978 (Supp. 78-4). R9-24-204 recodified from R9-24-124 (Supp. 95-2).

R9-24-205. Excluded Areas
Areas with a percent-demand-met score of 100 percent or greater and areas not qualifying according to the criteria described in R9-24-203 or R9-24-204 shall not be designated as medically-underserved by the Department.

Historical Note
Adopted effective July 27, 1978 (Supp. 78-4). R9-24-205 recodified from R9-24-125 (Supp. 95-2).

ARTICLE 3. COORDINATING MEDICAL PROVIDERS

R9-24-301. Functions

A. In addition to conforming to all other related Arizona statutory and regulatory requirements, the coordinating medical provider shall:
1. Be directly involved in planning for the delivery of medical services within the area covered by the agreement.
2. Assure access to medical and support services, either directly or by referral, for the residents of the medically-underserved area.
3. In conjunction with the nurse practitioners and physician assistants under his direction, develop written protocols which outline areas for independent judgment on the part of the nurse practitioners and the physician assistants.
4. Have final approval in the selection of nurse practitioners and physician assistants working under his direction.
5. Have authority over and responsibility for the medical direction of all nurse practitioners and physician assistants under his direction.
6. Arrange to evaluate medical care provided by nurse practitioners and physician assistants under his direction through face-to-face contact at least four times per month.
7. Recommend specific areas of medical education, including instruction in referral sources, and shall schedule coverage to allow for continuing medical education of all nurse practitioners and physicians assistants under his direction.
8. Meet at least annually with the governing board to evaluate the program and to devise methods to maximize the efficiency and improve the quality of medical care provided.

B. Nothing in these requirements is intended to contradict the minimum requirements for nurse practitioners, physician assistants and physicians required by Arizona law and regulation. These requirements may supplement the basic ones but in no case are they intended to reduce or eliminate other requirements of practice.

Historical Note
Adopted effective July 27, 1978 (Supp. 78-4). R9-24-301 recodified from R9-24-131 (Supp. 95-2).

ARTICLE 4. ARIZONA LOAN REPAYMENT PROGRAM

R9-24-401. Definitions
In this Article, unless the context otherwise requires:
1. "ADHS" means the Arizona Department of Health Services.
2. "ALRP" means Arizona Loan Repayment Program.
3. "Ambulatory care services" means all types of primary health care services.
4. "Clinical services" means primary health care services provided in a clinic.
5. "Commercial loans" means loans made by banks, credit unions, savings and loan associations, and other financial or credit institutions whose lending activities are subject to examination and supervision by a federal or state agency.
6. "Degree-of-shortage ranking" means a ranking assigned to a HPSA by the Secretary of Health and Human Services based on severity of need for primary care providers.
7. "Director" means the Director of the Arizona Department of Health Services.
8. "Health Professional Shortage Area" or "HPSA" means a service area designated by the U.S. Secretary of Health and Human Services as having insufficient primary care physicians pursuant to 42 CFR Part 5.
9. "Medically Underserved Area" or "MUA" means an area in Arizona designated by the state as medically underserved pursuant to A.R.S. § 36-2352.
10. "Minority" means Black, Hispanic, Native American, Eskimo, Aleut, Asian, or Pacific Islander.
11. "National Health Service Corps Health Professional Opportunities List" means the registry of vacancies for provider recruitment assistance approved by the U.S. National Health Service Corps.
12. "Nurse midwife" means a registered nurse practitioner who is certified by the state Board of Nursing to provide midwifery services.
13. "Nurse practitioner" means a registered nurse certified by the Arizona State Board of Nursing to function in an extended role pursuant to A.R.S. Title 32, Chapter 15, and who provides primary health care services.
14. "Physician" means a physician holding a current and valid Arizona license pursuant to A.R.S. Title 32, Chapter 13 or 17, who has completed a professional residency program accredited by the Accreditation Council for Graduate Medical Education of the American Medical Association, or the Executive Committee of the Council of Post-Doctoral Training of the American Osteopathic Association, in one of the following primary health care specialties: family practice or osteopathic general practice, obstetrics-gynecology, pediatrics, or internal medicine; and who is board certified in the primary health care specialty, or eligible to sit for the certifying exam.
15. "Physician assistant" means a person certified pursuant to A.R.S. § 32-2501, and who provides primary health care services.
16. "Primary health care professional" means physicians serving in the field of family practice, pediatrics, obstetrics, or internal medicine; nurse practitioners; certified nurse midwives; and physician assistants.

17 "Primary health care services" means services provided to persons that preserve health, prevent disease and dysfunction, and care for common illnesses and disabilities.
18. "Provider recruitment awards" means payments that are made available to eligible primary health care professionals who have qualifying educational loans and are beginning practice at an eligible service site.
19. "Provider retention awards" means payments that are made available to eligible primary health care professionals who have qualifying educational loans pursuant to R9-24-410 and who are already practicing at an eligible service site.
20. "Public or nonprofit private entity" means a migrant and community health center funded under Section 329 or 330 of the Public Health Service Act, 42 CFR 51(c); and, a health care entity that delivers primary health services targeted to underserved populations such as low-income individuals, pregnant women, children, the uninsured, the homeless, substance abusers, HIV-infected persons, and the elderly; or other system of care which provides a full range of primary and preventive health and social services and which is recognized as nonprofit under the United States Internal Revenue Code.
21. "Remote rural area" means a rural HPSA that is located 45 miles or more from a city or town with a population of 20,000 or greater.
22. "Rural" means a county with a population of less than 400,000, or a Census County Division with fewer than 50,000 persons in a county with a population of 400,000 or more persons.
23. "Service site" means the location where a public or nonprofit private entity provides primary health care services in a HPSA.
24. "Urban" means an area other than rural or remote rural.

Historical Note
Adopted effective March 17, 1995 (Supp. 95-1).

R9-24-402. Service Site Eligibility

A. To be eligible to participate in the ALRP, a service site shall meet the following qualifications:
1. Be a public or nonprofit private entity located and providing primary health care services in a HPSA.
2. Accept Medicare and Medicaid assignment.
3. Charge patients at the usual and prevailing rates in the area, and have a sliding-fee scale in place for patients based on their ability to pay for services.
4. Have a record of sound fiscal management as evidenced by audited financial statements for the most recent two years of operation.
5. Provide a written statement certifying that financial means are available to support a position that receives a loan repayment award, including salary benefits, and malpractice insurance expenses for a minimum of two years.

B. Primary health care professionals who are in for-profit solo or group practices are not eligible to participate in the ALRP, even though they are located in a HPSA.

C. Sites determined not to be eligible for loan repayment program participation may submit a written request to the Director within 15 days or receipt of the notice denying eligibility for a hearing appealing such denial. The appeal shall be conducted in accordance with the Department's rules of practice and procedure, A.A.C. Title 9, Chapter 1, Article 1.

Historical Note
Adopted effective March 17, 1995 (Supp. 95-1).

R9-24-403. Funding Set-Asides

A. ALRP funds shall be set aside each year for retention and recruitment loan repayment awards to primary care health professionals who contract to serve at eligible service sites in HPSA's in rural and remote rural areas of the state as follows:
1. 64% for awards in rural areas,
2. 20% for awards in remote rural areas.

B. Sixteen percent of the ALRP funding each year shall be set aside for loan repayment awards to primary health care professionals who contract to serve at eligible sites in HPSA's in urban areas of the state.

Historical Note
Adopted effective March 17, 1995 (Supp. 95-1).

R9-24-404. Annual Loan Repayment Award Cycle

A. ALRP loan repayment awards shall be made in three sequential phases during the state fiscal year. The first phase shall be for provider retention loan repayment awards. If funds remain after the retention award phase, there shall be a provider recruitment loan repayment award phase. If funds remain after the provider recruitment awards phase, there shall be a final award phase where all urban and rural set aside funds are collapsed into a general pool of funds available for recruitment loan repayment awards.

B. A schedule of the specific dates that each phase of the loan repayment cycle will open and close shall be published each year by ADHS at least three weeks prior to the start of the first phase of the cycle.

C. Each service site shall be eligible to receive only one retention and one recruitment loan repayment award during an annual award cycle. The restriction on one recruitment award per site shall be waived midway during phase three if ALRP funds still remain and sites with vacancies that have not received an award indicate they will be unable to match with an eligible provider.

Historical Note
Adopted effective March 17, 1995

R9-24-405. Site Vacancy Register Eligibility

A. Only eligible service sites with primary health care professional vacancies which are listed on the ALRP Site Vacancy Register and for which they are seeking loan repayment shall be eligible to participate in the ALRP.

B. Service sites which seek to be included on the site vacancy register shall complete and submit a Notification of Vacancy form as shown in Exhibit A to ADHS at the beginning of the annual loan repayment award cycle, or at any time throughout the cycle as requested.

C. In completing the form, sites may include both currently vacant positions and those anticipated to become vacant before the end of the annual loan repayment cycle.

D. Service sites determined by ADHS to meet the eligibility requirements of R9-24-402 shall be listed on the Vacancy Register by HPSA. The sites shall be ranked by score and prioritized in accordance with R9-24-406 and the vacancies at each site shall be listed.

E. More than one vacancy for each site may be listed on the Vacancy Register. Vacancies that appear on the National Health Service Corps Health Professional Opportunities List shall not be placed on the ALRP Vacancy Register. Sites shall determine in advance whether a vacancy is to be considered for loan repayment by the National Health Service Corps or by the ALRP.

Exhibit A. Notification of Vacancy for Participation in Arizona Loan Repayment Program (ALRP)

Arizona Loan Repayment Program
Office of Health Planning,
Evaluation and Statistics
Arizona Department of Health Services
1740 West Adams Street, Room 312
Phoenix, Arizona 85007
(602) 542-1216 FAX: (602) 542-1244

NOTIFICATION OF VACANCY

For Participation in Arizona Loan Repayment Program (ALRP)

Complete a separate application for each service delivery site. Use the instructions provided as a guide to completing this application.

Date submitted_____

1. Name of service site:_____

   Address:_____

   City:_____ County:_____

   Zip Code:_____

2. Name of HPSA service area:_____

   Federal degree-of-shortage ranking of the HPSA: (circle one) 1 2 3 4

3. Percent minority population in HPSA:_____

4. Is the practice located in a state-designated Medically Underserved Area (MUA)?

   Yes No

   Name of State MUA_____

5. How many miles is it from this site to the nearest city or town with a population of 20,000 or greater? _____

   Name of town:_____

6. Name of sponsoring organization:_____

   Address:_____

   City:_____Zip Code:_____

Executive director / manager's name:_____7.Type of organization:_____Public_____Private Non-Profit

_____Government (State/County/City) Specify:_____

_____University

_____Hospital

_____Public Health Services (PHS) Funded

_____Other Specify:_____

8. List each position eligible for participation in the ALRP and the following information for each position.

Discipline	Speciality	Retain Existing Provider? (List Name)	Length of Time Position Vacant	Projected Hire Date	Minority Preference?	Bilingual Preference?	Does Position Require Call Duty?

Discipline - Physician, Physician Assistant, Nurse Practitioner, Certified Nurse Midwife.
Specify NP or PA if only one is acceptable, or NPA if either is acceptable.

Speciality - Family Medicine, Internal Medicine, Pediatrics, OB/GYN.

Length of Time - Length of time vacant position has been actively recruited (in months).

Minority - Black, Hispanic, Asian, Native American, Other.

Bilingual - Specify language needed.

Call Duty - Put X for positions that require call after-hours at least every other night. Put OB for positions that require after-hours obstetric calls at least five night a week.

9. Name of site recruitment contact:_____

Title:_____Phone No._____

10. Site profile - please attach to this application a description of your site and geographic area including educational and recreational opportunities, churches in the area, industry information, etc.

11. Assurances (for executive director / manager's initial)

_____ A. Funds are available to support position(s) that receive a loan repayment award to include salary, benefits, and malpractice insurance expenses for a minimum of two years.

_____ B. We have a documented record of sound fiscal management.

_____ C. We accept people covered by Titles XVIII (Medicare) and XIX (Medicaid) and those who have no health insurance coverage.

_____ D. We charge patients at the usual and prevailing rates in the area, and have a sliding-fee scale in place for patients based on ability to pay.

_____ E. Any health professional awarded loan repayment funds will work full-time (a minimum of 40 hours a week) in their profession.

12. I certify that to the best of my knowledge and belief, all data provided in this application is true and correct.

Executive director / manager:

Name:_____

Title:_____Phone No._____
(If other than executive director)

Signature:_____Date:_____

Historical Note
Adopted effective March 17, 1995 (Supp. 95-1).

R9-24-406. Ranking of Eligible Sites

A. Service sites which meet the eligibility requirements of R9-24-402 and which complete and submit to ADHS a Notification of Vacancy form shall be assigned points for purposes of ranking and shall receive a total score based upon the following criteria and scales:

1. Whether the practice site is in a rural, remote rural, or urban HPSA

	Points
Remote Rural	4
Rural	2
Urban	0

2. Degree-of-shortage level ranking assigned by the Federal Office of Shortage Designation for the HPSA.

	Points
Level 1	4
Level 2	3
Level 3	2
Level 4	1

3. Whether the HPSA is located in a state-designated MUA.

	Points
Yes	4
No	0

4. The percent of minority population in the HPSA as set forth in the Arizona data from the most recent U.S. decennial census.

	Points
>50%	4
40-50%	3
30-39%	2
20-29%	1
<20%	0

5. Hardship characteristics at the practice site, including the presence of a hard-to-fill position, that is one which has been vacant and actively recruited 12 months or longer; or one that requires after-hours on call duty at least every other

	Points
Vacancy	2
After-hours Call	2
OB Call	2

B. Eligible service sites shall be prioritized for loan repayment placements and maximum award amounts based upon the total number of points assigned for the five criteria listed in subsection (A). Sites shall be ranked as Priority 1, 2, or 3 based on their total point score as follows:

Priority Rank	Total Points Required
1	14 - 22
2	8 - 13
3	<8

C. Information needed to establish priority for each service site shall be provided by the service site on the Notification of Vacancy form at the start of the retention and recruitment cycle each year in accordance with R9-24-405, or at any time during the cycle as requested.

Historical Note
Adopted effective March 17, 1995 (Supp. 95-1).

R9-24-407. Applicant Eligibility Criteria

A. To be eligible to participate in the ALRP, an individual shall comply with the following:

1. Be a U.S. Citizen.
2. Be a physician in the field of family practice, pediatrics, obstetrics, or internal medicine; or a nurse practitioner, certified nurse midwife, or physician assistant who provides primary care services.
3. Have completed the final year of a course of study or program in one of the licensed health professions listed above, or hold a current Arizona license or certificate in good standing in accordance with Arizona Revised Statutes, Title 32.
4. If a physician, shall have completed a professional residency program in a primary health care specialty, and be board certified or eligible to sit for the certifying examination in the speciality.
5. Provide evidence of current or prospective employment with an eligible service site.
6. Agree to contract with ADHS to serve full-time, 40 hours per week, at an approved service site for a minimum of two years, with one or two year contract extensions available to physicians upon mutual agreement with the service site.
7. Agree, with the exception of obstetrician / gynecologists and registered nurse midwives, to work at least 32 of the minimum 40 hours per week providing clinical services in the ambulatory setting at the approved service site during normally scheduled office hours. For an OB/GYN practitioner or registered nurse midwife, agree that not less than 21 hours per week shall be spent providing ambulatory care services during normally scheduled office hours.
8. Agree to charge for professional services at the usual and customary rates prevailing in the area, except that a patient unable to pay the charge shall be charged at a reduced rate or not charged.
9. Agree not to discriminate on the basis of the patient's ability to pay for care or the source of payment, including Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act, and participate in the Arizona Health Care Cost Containment System, Arizona Revised Statutes, Title 36, Chapter 22.
10. Have completely satisfied any other obligation for health professional service which is owed under an agreement with a federal, state, or local government, or other entity such as a health care facility/organization or community, prior to beginning a period of service under this program.

B. In addition to those individuals not meeting the requirements of subsection (A), the following individuals shall not be eligible to participate:

1. Persons who have breached a health professional services contract to the federal government, state, or local government, or other entity such as a health care facility/organization or community.
2. Persons who have a judgement lien against their property for a debt to the United States.

Historical Note
Adopted effective March 17, 1995 (Supp. 95-1).

R9-24-408. Application and Selection of Program Participants

A. Persons who desire to apply for loan repayment award shall complete a Health Professional Application as shown in Exhibit B, provide complete information on each loan they have taken out, provide evidence of compliance with the requirements of R9-24-407(A) and (B), and submit the application and required information to ADHS. All information shall be complete and accurate.

B. Applicants shall provide a copy of an agreement or contract signed by both the executive director or manger of the service site and the applicant evidencing current or prospective employment with the service site. The contract may specify

that the applicant shall be released from the contract if not selected for a loan repayment award.

C. Each program participant shall execute such consents or releases of information necessary for the Department to access loan records and acquire information from lenders necessary to verify eligibility and to determine payment amounts. Each loan repayment application shall be checked by ADHS program staff to assure it is complete, and all loan information shall be verified with each lender. ADHS staff shall review the application for eligibility for loan repayment and priority of the service site based upon criteria established in R9-24-406.

D. At the close of each phase of the loan repayment award cycle, ADHS staff shall review all loan repayment applications received during that phase, and make awards based on the priority of the applicants' service sites. Applicants shall be funded in order of the score their service site received pursuant to R9-24-406, with higher scores funded first, until available funds in rural and urban set-asides are exhausted. Any funds collapsed during phase three into a general pool shall be awarded to applicants based on the ranking of the service site. The amount of award shall be determined as prescribed by R9-24-410.

E. Persons determined not be be eligible to participate or not receiving awards in the loan repayment program may submit a written request for a hearing to the Director not later than 15 days after receipt of the notice denying the person eligibility or award. The appeal shall be conducted in accordance with the Department's rules of practice and procedure, A.A.C. Title 9, Chapter 1, Article 1.

Exhibit B. Health Professional Application

Office of Health Planning, Evaluation and Statistics
Arizona Department of Health Services
1740 West Adams Street, Room 312
Phoenix, Arizona 85007
(602) 542-1216 FAX: (602) 542-1244

HEALTH PROFESSIONAL APPLICATION

Arizona Loan Repayment Program

_____ ***PLEASE PRINT*** _____ Page 1 of 11

SECTION I

DATE:_____

Type of Application:
Retention Award_____
Recruitment Award_____

PERSONAL INFORMATION

1. Name: _____

(Last) (First) (Middle Initial)

2. Social Security Number: _____ Date of Birth _____
(Month/Day/Year)

3. Home Address_____
(Number) (Street) (Apt Number)

_____
(City) (State) (Zip)

4. Telephone Number: Home: ( ) _____ Other: ( ) _____

5. Work/School Address _____
Organization Name

_____
(Number) (Street) (Mail Stop)

_____
(City) (State) (Zip)

6. Work/School Telephone ( ) _____

7. Are You A Citizen of the United States? Yes _____No_____

If yes, attach a copy of your social security card, birth certificate, a U.S. passport, or naturalization papers.

8. Indicate Your Professional Status:

Physician_____Nurse Midwife_____
Nurse Practitioner_____Physician Assistant_____

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Arizona Department of Health Services
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Phoenix, Arizona 85007
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HEALTH PROFESSIONAL APPLICATION

Arizona Loan Repayment Program

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9. Indicate Your Professional Speciality

General Practice _____ OB/GYN _____
Family Medicine_____ Internal Medicine _____
Pediatrics_____ Other (Specify) _____

10. Subspecialty If Applicable:_____

11. Indicate Your Ethnic Category:

Asian or Pacific Islander_____ White, Non Hispanic_____
Native American_____ (Indian)Hispanic _____
Black_____ Other _____

12. Indicate Gender: Male_____ Female_____

13. Do You Fluently Speak: _____Spanish

_____Native Arizona Indian Language (Specify Which Language)_____

_____Other (Specify)

14. How Did You Find Out About This Program?

_____Arizona Health Providers Resources (AHPR)
_____Program Flyer
_____National Health Services Corps
_____Practice Site
_____Local AHEC Office
_____Friend
_____School/College Financial Aid Office
_____Professional Organization (Please specify)_____
_____Other (Please specify)_____

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SECTION II

Education Information

1. Type of Degrees Held:

BA/BS (Specify Major):_____MD_____
MA/MS (Specify Field):_____DO_____
Other:_____

Office of Health Planning, Evaluation and Statistics
Arizona Department of Health Services
1740 West Adams Street, Room 312
Phoenix, Arizona 85007
(602) 542-1216 FAX: (602) 542-1244

HEALTH PROFESSIONAL APPLICATION

Arizona Loan Repayment Program

2. Undergraduate Education (BA/BS):

Name of Institution: _____

Complete Address: _____

_____

Begin Date: _____ (Month/Year) Graduation Date:_____ (Month/Year)

Degree Obtained: _____

Name of School Reference: _____
(Last) (First) (Title)

3. Professional Education:(Post-Bachelor's)

Name of Institution: _____

Name of Program:_____

Program Address: _____

_____

Begin Date: _____ (Month/Year) Graduation Date _____ (Month/Year)

Name of Program Reference_____
(Last) (First) (Title)

Telephone: ( ) _____

4. Post-Graduate Professional Training: (Internship)

Name of Institution: _____

_____

Affiliated with what University or Medical Program: _____

_____

Complete Address: _____

_____

Office of Health Planning, Evaluation and Statistics
Arizona Department of Health Services
1740 West Adams Street, Room 312
Phoenix, Arizona 85007
(602) 542-1216 FAX: (602) 542-1244

HEALTH PROFESSIONAL APPLICATION

Arizona Loan Repayment Program

Begin Date: _____ Graduation Date: _____
(Month/Year) (Month/Year)

Name of Program Reference _____
(Last) (First) (Title)

Telephone: _____

5. Post-Graduate Professional Training: (Residency)

Name of Institution: _____

_____

Affiliated with what University or Medical Program: _____

_____

Complete Address: _____

_____

Begin Date: _____ Graduation Date: _____
(Month/Year) (Month/Year)

Name of Program Reference _____
(Last) (First) (Title)

Telephone: ( ) _____

==========

SECTION III

CREDENTIALS AND CERTIFICATIONS

1. Licensing:

Type of License: _____

State of Licensing: _____ License Number: _____

License Term: Start: _____ Expiration: _____

Office of Health Planning, Evaluation and Statistics
Arizona Department of Health Services
1740 West Adams Street, Room 312
Phoenix, Arizona 85007
(602) 542-1216 FAX: (602) 542-1244

HEALTH PROFESSIONAL APPLICATION

Arizona Loan Repayment Program

Description of License Restrictions (If Any): _____

_____

_____

2. Certification (Including Board Certification):

Type of Certificate: _____

State of Certification: _____ Certificate Number: _____

Certification Term: Start: _____ Expiration: _____

Description of Certification Restrictions (If Any): _____

_____

_____

==========

SECTION IV

PROFESSIONAL EMPLOYMENT EXPERIENCE

1. Practice Site Information: Provide name and contact (director or official) of site where you practiced since completing your medical training.

a. Name: _____ Title: _____

Address: _____
(Complete Site Name)

_____
(Number) (Street) (Site Number)

_____
(City) (State/Province) (County) (Zip Code)

Telephone: ( ) _____

2. Practice Site Information: Provide name and contact (director or official) of site where you practiced since completing your medical training.

Office of Health Planning, Evaluation and Statistics
Arizona Department of Health Services
1740 West Adams Street, Room 312
Phoenix, Arizona 85007
(602) 542-1216 FAX: (602) 542-1244

HEALTH PROFESSIONAL APPLICATION

Arizona Loan Repayment Program

a. Name: _____ Title: _____

Address:_____
(Number) (Street) (Site Number)

_____
(City) (State/Province)(County) (Zip Code)

Telephone: ( ) _____

3. Practice Site Information: Provide name and contact (director or official) of site where you practiced since completing your medical training.

a. Name: _____ Title: _____

Address:_____
(Complete Site Name)

_____
(Number) (Street) (Site Number)

_____
(City) (State/Province) (County) (Zip Code)

Telephone:_____

If you have additional employment experience, attach information on a separate piece of paper, with your name and social security number at the top

==========

SECTION V

EXISTING OR PRIOR SERVICE COMMITMENTS

1. Do you have any existing service obligations? Yes_____ No_____

If yes, Name of Program: _____

Complete Address: _____

_____

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HEALTH PROFESSIONAL APPLICATION

Arizona Loan Repayment Program

Contact Entity: _____

Telephone Number: ( ) _____

Terms of obligation: _____

_____

2. Are you in default of this or any other obligation:Yes_____No_____

If yes, describe circumstances: _____

_____

_____

==========

SECTION VI

SERVICE COMMITMENT FOR ARIZONA LOAN REPAYMENT AWARD

1. Service/Employer: Community-Based Primary Care Center:_____ Other_____

2. Location of Service: _____

3. Employer and Address:_____

_____

_____

Telephone: ( ) _____

Name of Center Director/Administrator: _____

4. Obligation Service Dates:

Start: _____ Completion Date: _____

5. Attach Documentation (Signed Employment Contract) of Current or Prospective Employment at Practice Site.

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HEALTH PROFESSIONAL APPLICATION

Arizona Loan Repayment Program

SECTION VII

PROFESSIONAL REFERENCE

1. Reference Name: _____ Title: _____

   Complete Address: _____

   _____

   _____

   (City)(State) (Zip Code) (Telephone)

2. Reference Name: _____ Title: _____

   Complete Address: _____

   _____

   _____

   (City)(State) (Zip Code) (Telephone)

3. Reference Name: _____ Title: _____

   Complete Address: _____

   _____

   _____

   (City)(State) (Zip Code) (Telephone)

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Arizona Department of Health Services
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HEALTH PROFESSIONAL APPLICATION

Arizona Loan Repayment Program

SECTION VIII

LOAN INFORMATION

Please copy and complete this form for each loan which you are applying to have repaid under the Arizona Loan Repayment Program. This form will be sent to each of your lenders for verification.

Name of Lender: _____

Complete Address of Lender: _____

_____

Telephone Number: ( ) _____

Lending Institution's Tax Identification Number: _____

Loan Identification Number: _____

Original Amount of Loan: $ _____

Current Balance: _____ $ _____ Date of this balance: _____
(Month/Year)

Monthly Payment Amount: $ _____ Number of payments made: _____

Term of Loan/Number of Payments Remaining: _____ / _____

Interest Rate: _____%Simple Interest? Yes _____ No_____

If other than simple interest, explain: _____

_____

Provide purpose(s) of loan(s) as indicated on loan application(s): _____

_____

Academic period covered by this loan: _____ to _____
(Month/Year) (Month/Year)

_____

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Arizona Department of Health Services
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Phoenix, Arizona 85007
(602) 542-1216 FAX: (602) 542-1244

HEALTH PROFESSIONAL APPLICATION

Arizona Loan Repayment Program

PLEASE PRINT

Certification by Applicant Borrower and Release of Loan Information

I hereby certify to the accuracy of the previous information and apply to enter into an agreement with the State of Arizona for repayment of all or the appropriate portion of the education loan(s) listed in Section VIII hereof, which loans were incurred solely for the costs of medical education, including reasonable living expenses. I hereby authorize the government or financial institution named in Section VIII to release this information about the loan listed in Section VIII to the administrators of the Arizona Loan Repayment Program.

Legal Signature of Applicant _____ Date: _____

Social Security Number of Applicant: _____

Name as it appear\s on loan: _____
(Print or Type)

Lending Institution's Certification

The undersigned states that, to the best of his or her knowledge, the loan identified in Section VIII is a bona fide legally enforceable commercial, state, or government educational loan made for the purpose of meeting the borrower's costs of attending undergraduate school or graduate school in a health profession.

Government / State or Bank Authorized Official

Signature: _____ Date: _____

Title: _____

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Arizona Department of Health Services
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Phoenix, Arizona 85007
(602) 542-1216 FAX: (602) 542-1244

HEALTH PROFESSIONAL APPLICATION

Arizona Loan Repayment Program

Section IX

Certification

1. I hereby certify that, to the best of my knowledge, the loans identified in this application are professional medical educational loans, incurred solely for the costs of medical education, including reasonable living expenses, at an undergraduate school, or a school of medicine, osteopathy, or other health profession; and that the loan amounts do not reflect consolidated loans for other purposes.

2. I hereby certify that, to the best of my knowledge, the information contained in this application is accurate, and authorize the Arizona Department of Health Services or its designee to verify all information presented.

WARNING:

Any person who knowingly makes a false statement or misrepresentation or material omission in this loan repayment application, fraudulently obtains repayment for a loan, or commits any other illegal action in connection with this transaction is subject to fine or imprisonment. I have read this statement and understand its contents.

Typed or Print _____

Social Security Number: _____

Signature: X _____ Date:_____

State of Arizona)
)
County of)

The foregoing instrument was acknowledged before me this_____ day of _____
by_____ .

My Commission Expires: _____
Notary Public

PLEASE SEND YOUR CURRICULUM VITAE WITH THIS APPLICATION

Historical Note
Adopted effective March 17, 1995 (Supp. 95-1).

R9-24-409. Loans Qualifying for Repayment

A. Repayment shall be available for the principal, interest, and related expenses of government and commercial loans taken out by the participant for the following:
1. Actual costs paid for school tuition and required fees for undergraduate and graduate education.
2. Reasonable education expenses required by the undergraduate and graduate school, including books, fees, laboratory expenses, educational equipment and supplies.
3. Reasonable living expenses, including room and board, transportation costs, and other costs paid during an individual's attendance at a college, university or health professions school, which are equal to or less than the school's estimated standard student budget.

B. Obligations or debts incurred under any of the following programs shall not be eligible for repayment:
1. National Health Service Corps Scholarship Program,
2. Armed Forces Health Professional Scholarship Program,
3. Indian Health Service Scholarship Program, or
4. Arizona Medical Student Loan Program.

C. Any professional practice performed prior to the effective date of the ALRP contract, including any practice done while the provider is in professional school or a graduate training program shall not count toward satisfying a period of obligated service under this contract.

D. Loan repayment awards shall not be used to pay loans from family members.

Historical Note

Adopted effective March 17, 1995 (Supp. 95-1).

R9-24-410. Allowable Award Amounts

A. The amount of the loan repayment award for a primary care physician shall be determined based upon the priority ranking assigned to the service site at which the physician plans to serve the two-year contract obligation and the physician's total student loan indebtedness. Physicians shall be awarded amounts according to the following schedule:

Contracted Years of Service — Maximum Awards Amount Allowable By Priority of Service Site

	Priority 1	Priority 2	Priority 3
1st year	$20,000	$18,000	$16,000
2nd year	$20,000	$18,000	$16,000
3rd year	$22,000	$20,000	$18.000
4th year	$25,000	$22,000	$20,000

B. A nurse practitioner, certified nurse midwife, or physician assistant shall receive a loan repayment award of up to $7,500 per year depending upon the priority ranking of the service site at which the provider contracts to serve and the provider's total student loan indebtedness. Maximum award amounts are as follows:

Contracted Years of Service — Maximum Awards Amount Allowable By Priority of Service Site

	Priority 1	Priority 2	Priority 3
1st year	$7,500	$6,000	$5,000
2nd year	$7,500	$6,000	$5,000

C. An award to a recipient shall not exceed the recipient's total student loan indebtedness. Loan repayment awards shall be in addition to any salary or compensation the provider receives from employment at the service site.

D Awards to loan repayment recipients shall be for continuous service during the two-year contract period in accordance with the agreements set forth in R9-24-407.

E. The recipient shall receive the amount of loan repayment requested unless it exceeds the maximum amount allowable pursuant to subsections (A) and (B), or unless there is inadequate funding left to provide the maximum amount allowable and the recipient agrees to contract for a lesser amount.

F. Loan repayment to lenders shall be restricted to a maximum of three lending institutions for each recipient. Upon receipt of the award notification letter, the recipient shall complete and return to ADHS a Priority for Repayment form setting forth the priority of payment to the lenders and providing the following information for each lender:
1. Name of the lending institution,
2. Address,
3. Telephone number,
4. Contact person,
5. The lending institution's tax identification number,
6. The loan identification number,
7. Loan amount,
8. Interest rate,
9. Monthly payment amount, and
10. Balance remaining on the loan.

Historical Note

Adopted effective March 17, 1995 (Supp. 95-1).

R9-24-411. Contracting Process

A. An applicant who receives a loan repayment award shall execute a contract with ADHS as shown in Exhibit C to provide services in exchange for loan repayment. The recipient shall sign and return the contract to ADHS.

B. The contract shall become a binding agreement in which ADHS agrees to make payments on the participant's qualified loans and the participant agrees to provide services according to the specification of the contract upon signature of the Director or the Director's designee. The effective date for the start of obligated service shall be stated in the contract.

Exhibit C. Arizona Loan Repayment Program Contract

CONTRACT NUMBER	**SIGNATURE PAGE**	**PAGE 1**

1. Type of Solicitation: **Not Applicable**

2. Type of Procurement: **Pursuant to A.R.S. §36-2172, Primary Care Provider Loan Repayment**

3. Project Title: **Arizona Loan Repayment Program**

4. Geographic Service Area: (as stated in Section C. of the Work Statement)

5. ADHS authority to contract for services specified herein: **A.R.S. §§36-104, 36-132 and 36-2172**

6. Contractor represents that he is authorized to contract for the performance of, and to perform the services provided herein pursuant to:

   Sole Proprietor

7. Term:Effective Date:

   Termination Date:

8. CONTRACTOR AGREES to perform all the services set forth in the attached Work Statement for the consideration stated herein. The rights and obligations of the parties to this Contract shall be subject to and governed by the General Provisions. To the extent of any inconsistency between the General Provisions and the Work Statement, the terms of the Work Statement shall govern. To the extent of any inconsistency between the Work Statement and the Payment and Budget Page, the terms of the Payment and Budget Page shall govern. To the extent of any inconsistency between the General Provisions, Work Statement, Payment and Budget Page and the Signature Page, the terms of the Signature Page shall govern. Amendments signed by each of the parties and attached hereto are hereby adopted by reference as a part of this Contract, from the effective date of the Amendment, as if fully set out herein.

9. IN WITNESS WHEREOF, the parties hereto have executed this Contract on the date specified below.

10. NAME AND ADDRESS OF CONTRACTOR:		**11. ARIZONA DEPARTMENT OF HEALTH SERVICES 1740 WEST ADAMS STREET**	
12. SIGNATURE OF AUTHORIZED INDIVIDUAL:	**13. DATE**	**14. SIGNATURE OF AUTHORIZED INDIVIDUAL:**	**15. DATE**
16. TYPED NAME AND TITLE:		**17. TYPED NAME AND TITLE:**	

1. DEFINITIONS:

As used throughout this document, the following terms shall have the meanings set forth.

a. "ADHS" means the Arizona Department of Health Services.

b. "Contractor" means the person, firm, or organization performing, or accountable for performing the services or delivering the items described in this Contract.

c. "Department" means the Arizona Department of Health Services.

d. "Director" means the Director of the Arizona Department of Health Services or his duly authorized representative.

e. "EDA" means effective date of Amendment.

f. "Fixed Price" means a set price per unit of measurement as specified in the Contract.

g. "Professional acts" means services or acts of persons whose vocation or occupation requires special, usually advanced, education and skill which is predominantly mental or intellectual rather than physical or manual.

h. "Program Director" means the person designated to represent the Department only in the program administration of this Contract. The Program Director does not have authority to waive or amend Contract requirements.

i. "Reimbursement" means the payment method whereby payment(s) shall be made upon receipt of the approved Service Verification Form.

j. "Service Recipients" means persons who are eligible for services provided by the Department or its authorized Contractor.

k. "Shall" means mandatory.

l. "State" means the State of Arizona.

m. "Work Statement" means those provisions of this Contract which delineate the scope and manner of the specific services to be performed and/or describe the items to be supplied in the performance of this Contract. If the provisions of the Work Statement conflict with the General Provisions, the terms of the Work Statement shall govern.

2. GENERAL REQUIREMENTS:

a. This Contract, and any amendments thereto, shall become effective on the date specified (t)herein.

b. The Contractor, unless otherwise exempt by law, shall obtain and maintain all licenses, permits and authority necessary to do business and render services under this Contract.

c. This Contract may be extended for physicians only, by mutual agreement of both parties, for a period not to exceed four years from the original effective date.

d. The parties hereto agree that the Contractor is an independent Contractor in the performance of this Contract and is not an officer, employee or agent of the State

e. No individual employed by the State shall have a substantial interest in this Contract or receive a substantial benefit that may arise therefrom.

f. Contractors receiving both Federal and State funds under this Contract shall comply with the certified financial and compliance audit provisions of Office of Management and Budget Circular A-128 or A-133, whichever is applicable and the certified financial and compliance audit provisions of A.R.S. § 35-181.03.

3. OTHER CONTRACTS:

The Department may perform additional work related to this Contract or award other Contracts for such work. The Contractor shall cooperate fully with such other Contractors and/or State employees in scheduling and coordinating its work with such additional work. The Contractor shall afford other Contractors reasonable opportunity for the execution of their work and shall not commit or permit any act which will interfere with the performance of work by any other Contractor or by State employees. The Department shall equitably enforce this Section as to all Contractors to prevent unreasonably burdening any Contractor.

4. ASSIGNMENTS:

The Contractor's rights or obligations under this Contract shall not be assigned without the prior written consent of the Department. The Director may void the Contract if the Contractor becomes insolvent or files bankruptcy or reorganization proceedings under Title XI, United States Code.

5. OWNERSHIP OF INFORMATION:

The Contractor agrees to give recognition to the Department for its support of the program when publishing program material or releasing program related public information.

6. CONFIDENTIALITY OF RECORDS:

The Contractor shall establish and maintain written procedures and controls that comply with Arizona Administrative Code (A.A.C.) R9-1-311 through R9-1-315 regarding disclosure of confidential medical information and records. Upon Department approval of Contractor's written procedures governing confidentiality, the Contractor may release information pursuant to its approved procedures. In the absence of approved procedures, requests for medical information shall be in writing and disclosure authorized by the Department, or where permitted by the rules, by the director of a local health Department. No medical information contained in Contractor's records or obtained from the Department or from others in carrying out its functions under this Contract shall be used or disclosed by Contractor, its agents, officers or employees except as is essential to the performance of duties under this Contract or otherwise permitted under the statutes and rules of the Department. Disclosure to the Department is deemed

essential to the performance of duties under this Contract. Neither medical information nor names or other information regarding any person applying for, claiming, or receiving items or services contemplated in this Contract, or any employer of such person shall be made available for any political or commercial purpose. Information received from a Federal agency or from any person or provider acting under the Federal agency pursuant to Federal law, shall be disclosed only as provided by Federal law.

7. RECORDS:
   a. Contractors who submit cost or pricing data as provided in A.R.S. § 41-2543 shall maintain books and records which reflect that cost or pricing data under the Contract and shall reflect the Contract services and expenditures. All books and records shall be maintained in accordance with Generally Accepted Accounting Principles (GAAP).
   b. Contractor further agrees:
      (1) To submit all reports and invoices as specified in the Work Statement of this Contract.
      (2) The Contractor shall preserve and make available to the Department and its auditors all records for a period of five (5) years from the date of final payment under this Contract and for such period as is required by any other paragraph of this Contract including the following:
      (a) If this Contract is completely or partially terminated, the re cords relating to the work terminated shall be preserved and made available for a period of five (5) years from the date of any such termination.
      (b) Records which relate to disputes, litigation or the settlement of claims arising out of the performance of this Contract or to cost and expenses of this Contract to which exception has been taken by the Director shall be retained by the Contractor until such appeals, litigation, claims or exceptions have been finally resolved.
      (c) If requested, the Contractor shall submit such records relating to the Contract to the address specified in Section D.2 of the Work Statement.
8. INDEMNIFICATION:
   a. The Contractor shall at all times indemnify, defend and save harmless the State and/or any of its agents, officials and employees from any and all claims, demands, suits, actions, proceedings, loss, cost and/or damages of every kind and description including any attorney's fees and/or litigation expenses brought or made against or incurred by the State on account of loss of or damage to any property or for injuries to or death of any person caused by, arising out of, or contributed to, in whole or in part, by reasons of any alleged act, omission, professional error, fault, mistake, or negligence of the Contractor, its employees, agents, representatives, or Subcontractors, their employees, agents, or representatives in connection with or incident to the performance of this Contra ct or arising out of Workers' Compensation claims, Unemployment Compensation claims, or Unemployment Disability Compensation claims of employees of the Contractor and/or its Subcontractors or claims under similar such laws or obligations. The Contractor's obligation under this paragraph shall not extend to any liability caused by the sole negligence of the State or its employees.
   b. The Department shall not be liable for damages to Contractor caused by late disbursement of loan repayment proceeds.

9. WARRANTY:

The Contractor warrants that all services shall be performed in conformity with the requirements of this Contract by qualified personnel in accordance with generally recognized standards.

10. AMENDMENTS AND NOTICES:

a. No condition or requirement contained in or made a part of this Contract shall be waived or modified without an approved, written amendment to this Contract. Amendments shall be effective only if in writing and signed by all parties.

b. Subsection (a) above notwithstanding, Contractor shall give notice to the Department of any non-material alteration to this Contract. Non-material alterations do not require a written amendment and are:

(1) Change of address.
(2) Change of telephone number.
(3) Change of authorized signatory.
(4) Changes in the name and/or address of the person to whom notices are to be sent.
(5) Change in the name of the Contractor where the ownership remains the same.

c. Subsection (a) above notwithstanding, a written amendment shall not be required for funding source change(s) by the Department when the amount of the Contract remains unchanged.

d. Whenever notice is required pursuant to the terms of this Contract, said notice shall be in writing, shall be delivered in person or by certified mail, return receipt requested, and shall be directed to the persons and addresses specified for such purpose in Section D of the Work Statement or to such other persons and/or addresses as either party may designate to the other party by written notice.

11. DISPUTES:

a. In the event of a dispute under this Contract, the parties agree to make a good faith attempt to resolve the dispute prior to taking formal action.

b. The parties agree to make use of arbitration in all Contracts subject to mandatory arbitration pursuant to rules adopted under A.R.S. § 12-133.

c. This Contract shall be construed in accordance with Arizona law and any legal action thereupon shall be initiated in an appropriate court of the State of Arizona.

12. TERMINATION OF CONTRACT:

The Department or the State may terminate this Contract under the following conditions:

a. The Director, in addition to other rights set forth elsewhere in the Contract, reserves the right to terminate this Contract in whole or in part without cause effective thirty (30) days after mailing written notice of termination by certified mail, return receipt requested to the Contractor. Upon such

termination, the Contractor shall deliver to the Department a complete set of all documents, programs and other information described in the Contract.

b. The Director may also terminate this Contract in whole or in part if, during the term of this Contract, the Contractor is listed on the Master List of debarments, suspensions and voluntary exclusions maintained pursuant to A.A.C. R2-7-933. In such case, the Director shall transmit written notice of termination to the Contractor by certified mail, return receipt requested, and this Contract shall be terminated effective upon receipt thereof by the Contractor or such later date as is specified in the notice. In the event the Director terminates this Contract in whole or in part as provided in this subsection, subsection (b), (c), (e) and (f) of Section 13 are incorporated into this Subsection by reference and shall apply to the same extent as if expressly set out herein.

c. The Director may terminate this Contract by written notice to the Contractor if it is found by the Director after notice and opportunity for a hearing that gratuities in the form of entertainment, gifts, or otherwise were offered or given by the Contractor or any agent or representative of the Contractor to any officer or employee of the State with a view toward securing a Contract or securing favorable treatment with respect to the awarding or amending or the making of any determinations with respect to the performing of such Contract.

d. Pursuant to A.R.S. § 38-511 the Department may, within three (3) years after its execution, cancel this Contract without penalty or further obligation by the Department if any person significantly involved in initiating, negotiating, securing, drafting or creating this Contract on behalf of the Department is, at any time while the Contract or any extension of the Contract is in effect, an employee or agent of any other party to the Contract in any capacity or a consultant to any other party of the Contract with respect to the subject matter of the Contract. Cancellation under this subsection by the Department shall be effective when written notice from the Department is received by all other parties to the Contract unless the notice specifies a later time. In addition to the right to cancel this Contract as provided in this Subsection, the Department may recoup any fee or commission paid or due to any person significantly involved in initiating, negotiating, securing, drafting or creating this Contract on behalf of the Department from any other party to this Contract arising as the result of this Contract.

e. This Contract may be terminated by mutual written agreement of the parties specifying the termination date therein.

13. DEFAULT:

a. The Director, in addition to other rights set forth elsewhere in the Contract, may at any time terminate this Contract in whole or in part if the Director determines that the Contractor has failed to perform any requirement.

b. The Contractor shall continue the performance of this Contract to the extent not terminated.

c. If this Contract is terminated as provided herein, the Director, in addition to any other rights provided in this Section, may require the Contractor to transfer title and deliver to the State, in the manner and to the extent directed by the Director, such partially completed reports or other documentation as the Contractor has specifically produced or specifically acquired for the performance of such part of this Contract which has been terminated. Payments for completed reports and other documentation delivered to and accepted by the Director shall be at the Contract price.

d. The rights and remedies of the Department enumerated in this Section shall be in addition to any other rights and remedies provided by or under this Contract by law.

14. NON-DISCRIMINATION:

The Contractor shall comply with Title VII of the Civil Rights Act of 1964, as amended, the Age Discrimination in Employment Act of 1975 and the Federal Executive Order 11246, State Executive Order No. 75-5 and A.R.S. § 41-1461 et seq., which mandate that all persons, regardless of race, color, religion, sex, age, national origin or political affiliation, shall have equal access to employment opportunities. The Contractor shall comply with Section 503 of the Rehabilitation Act of 1973, as amended, which prohibits discrimination in the employment or advancement in employment of qualified persons because of physical or mental handicap. The Contractor shall comply with Title VI of the Civil Rights Act of 1964, as amended, which prohibits the denial of benefits or participation in Contract ser-vices on the basis of race, color, or national origin. The Contractor shall comply with the requirements of Section 504 of the Rehabilitation Act of 1973, as amended, which prohibits discrimination on the basis of handicap in delivering Contract services. The Contractor shall comply with the Americans With Disabilities Act of 1990 (Public Law 101-336) and the Arizona Disability Act of 1992 (A.R.S. § 41-1492 et seq.) which prohibit discrimination on the basis of physical or mental disabilities in delivering contract services or in the employment or advancement in employment of qualified persons.

15. ASSIGNMENT OF OVERCHARGES:

The Contractor, the Department and the State recognize that in actual economic practice overcharges resulting from antitrust violations are in fact borne by the purchaser. Therefore, the Contractor hereby assigns to the Department and the State any and all claims for such overcharges.

16. CONTRACT PAYMENTS:

a. Payments made by the Department pursuant to this Contract are conditioned upon the availability to the Department of funds authorized for expenditure in the manner and for the purposes provided herein. The Department shall not be liable for any purchases entered into by the Contractor in anticipation of such funding.

b. Payments made by the Department are conditioned upon receipt of applicable, accurate and complete reports from the Contractor.

c. If the Contractor is in any manner in default in the performance of any obligation under this Contract, or if audit exceptions are identified, the Department may, at its option and in addition to other available remedies, either adjust the amount of payment or withhold payment until satisfactory resolution of the default or exception. The Contractor shall have the right to written notice of the Department's action in adjusting the amount of payment or withholding payment. Under no circumstances shall the Department authorize payments that exceeds an amount specified in the Contract without an approved written amendment to the Contract. The Department may, at its option, withhold final payment under the Contract until receipt of all final reports and deliverables.

17. RECOUPMENT OF CONTRACT PAYMENTS:

a. Unacceptable Expenditures

The Contractor agrees to reimburse the Department for all Contract funds expended which are determined by the Department or the Auditor General not to have been disbursed in accordance with the terms of this Contract.

b. Contracted Services

Contractors who do not complete the service obligation pursuant to this Contract shall be liable to the Department for liquidated damages in an amount equivalent to twice the total uncredited amount of the loan repayment contracted for on a prorated monthly basis. The Department may waive the liquidated damages provision of this section if the Department determines that death or permanent physical disability accounted for the failure of the Contractor to fulfill the Contract.

c. Refunds

The liquidated damages stated in 17(b) above shall be paid to the Department within one year of the date of default. If the Contractor does not make payment within this time period, the Department may institute legal action to enforce repayment, and may:

(1) Recover interest on the liquidated damages at the legal rate of ten percent (10%) per annum;

(2) Recover the costs of a collection agency;

(3) Recover attorney's fees and costs incurred in collecting payment of the liquidated damages.

18. VISITATION AND INSPECTION:

The Contractor agrees that the Department and any other appropriate agent of the State or Federal Government, or any of their duly authorized representatives, shall have access during reasonable hours to the Contractor's facilities and the right to examine Contractor's books, documents and records involving transactions related to this Contract.

19. INFRINGEMENT OF PATENTS AND COPYRIGHTS:

a. The Contractor, at its own expense, shall defend any claim or suit which may be brought against the State for the infringement of United States patents or copyrights arising from the Contractor's use of any equipment, materials, or information prepared or developed in connection with performance of this Contract and in any suit shall satisfy any final judgment for such infringement. The Department shall give the Contractor written notice of such claim or suit and full right and opportunity to conduct the defense thereof, together with full information and all reasonable cooperation.

b. If principles of governmental or public law are involved, the State may participate in the defense of any such action, but no costs or expenses shall be incurred for the account of Contractor without written consent.

c. If, in the Contractor's opinion the equipment, materials or information mentioned in Subsection a above is likely to or does become the subject of a claim of infringement of a United States patent or copyright, then without diminishing the Contractor's obligation to satisfy any final award, the Contractor may, with the Director's written consent, substitute other equally suitable equipment, materials and information, or at the Contractor's option and expense, obtain the right for the Contractor or the Department to continue the use of such equipment, material and information.

CONTRACT NUMBER

WORK STATEMENT

PAGE 9

ARIZONA LOAN REPAYMENT PROGRAM

A. PURPOSE OF CONTRACT: For repayment of the qualifying educational loans of primary care physicians, nurse practitioners, certified nurse midwives, and physician assistants in exchange for their provision of primary care provider services at an approved site in a Health Professional Shortage Area (HPSA) for the term of this contract.

B. SERVICE RECIPIENTS: HPSA residents.

C. FACILITY LOCATION(S):

Services provided under this Contract shall be delivered at the following locations(s):

1. NAME AND ADDRESS: DAYS/HOURS OF OPERATION:
   As scheduled.
2. SUBCONTRACTOR(S) DAYS/HOURS OF OPERATION:
   N/A N/A

D. NOTICES, CORRESPONDENCE, REPORTS AND PAYMENTS:

1. Reporting Requirements to the Arizona Department of Health Services (ADHS):
   a. Fiscal: The Contractor shall submit a Service Verification Form verifying that the terms of the contract have been met on a quarterly basis. The Service Verification Form shall be submitted within 10 days after the end of each of quarter (three month period of service) beginning on the effective date of the contract.
   b. Programmatic: N/A
2. Notices, Correspondence and Reports from the Contractor shall be sent to:
   Arizona Loan Repayment Program Manager
   Office of Health Planning, Evaluation and Statistics
   Arizona Department of Health Services
   1740 West Adams, Room #312
   Phoenix, AZ 85007
3. Notices, Correspondence and Reports from the ADHS shall be sent to:
   (Name of Contractor and address)

CONTRACT NUMBER

GENERAL PROVISIONS

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4. Quarterly loan payments from the ADHS will be sent directly to the Contractor's lenders as listed below:
   a. Lending Institution:
      Department:
      Address:

      Telephone:
      Loan Number:
      Tax Identification Number:

   b. Lending Institution:
      Department:
      Address:

      Telephone:
      Loan Number:
      Tax Identification Number:

   c. Lending Institution:
      Department:
      Address:

      Telephone:
      Loan Number:
      Tax Identification Number:

CONTRACT NUMBER

WORK STATEMENT

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E. LICENSURE/CERTIFICATION REQUIREMENTS:

In addition to General Provisions 2.b., the Contractor shall also obtain and/or maintain the following license(s) and/or certification(s):

1. Personnel: Each primary health care provider shall have a current Arizona license or certificate as required by the specific licensure/certification requirements for their particular health profession. Physicians shall have completed a professional residency program in Family Practice, Pediatrics, Obstetrics, or Internal Medicine.

2. Facility: N/A

F. RESTRICTIONS:

1. In providing health services, Contractor shall not discriminate against any person on the basis of ability to pay for services or because payment for the health services provided will be made pursuant to the program established in Title XVIII (Medicare) of the Social Security Act or pursuant to the program established in Title XIX (Medicaid) of such Act.

2. Contractor must be a United States citizen.

3. Contractor must not have previously incurred an obligation for health professional service to the Federal, State or local government, or other entity unless said obligation(s) is completely satisfied prior to the beginning of service under this contract.

4. Contractor is not in breach of a health professional service contract to the Federal government, State or local government or other entity.

5. Contractor does not have a judgment lien against property for a debt to the United States.

6. Contractor is not allowed to use funds received under this agreement for any professional practice performed prior to the effective date of this agreement. This restriction on use of funds includes any practice performed while the provider is in a professional school or graduate training program.

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WORK STATEMENT

PAGE 12

G. SCOPE OF WORK:

MEDICAL AND RELATED SERVICES

These services pertain to medical care that is performed by physicians, dentists, oral surgeons, or specialists in a discipline necessary for the maintenance or improvement of health (i.e., optometrists,psychologists, genetic counselors) or at the direction of a physician.

1. ACTIVITY: The Contractor shall provide primary health care services at an approved site in a federally designated HPSA in Arizona. The primary health care professional shall:

a. with the exception of obstetrician/gynecologists (OB/GYN), work a minimum of forty (40) hours a week with at least thirty-two (32) of the minimum 40 hours per week providing clinical services in the ambulatory setting at the approved service site, during normally scheduled office hours. OB/GYN practitioners and certified nurse midwives must provide ambulatory care services during normally scheduled office hours the majority of the 40 hours per week (not less than 21 hours per wee).

b. charge for professional services at the usual and customary prevailing rates in the area(s) in which such services are provided, except that if a person is unable to pay such charge(s), such person shall be charged at a reduced rate or not charged any fee.

c. accept an assignment for payment under the terms specified in Title XVIII (Medicare) of the Social Security Act, Section 18.42(b)(3)(B)(ii).

d. enter into an agreement with the Arizona Health Care Cost Containment System (AHCCCS) to provide services to individuals entitled to medical assistance thereunder.

2. SERVICE DELIVERY METHODOLOGY:

Provide primary health care services in accordance with the terms and requirements of the employment contract with the approved service site.

3. EVALUATION METHODOLOGY:

Quarterly Service Verification Forms submitted.

CONTRACT NUMBER

PAYMENT AND BUDGET

PAGE 13

1. Contract Term:
2. Compensation Type: **Fixed Price**
3. Payment Method: **Reimbursement**
4. Billing Method: **Quarterly Invoice**
5. Source of Funds

   Federal (*CFDA # 93.165)$

   State: $

   Other $

   ADHS Share $

   Contractor's Match:$

   Contract Total:$

6.UNITS AND FUNDING SCHEDULE

Budget Term	Lending Institution	No. Units	Type of Units	Unit Rate	Total

Historical Note
Adopted effective March 17, 1995 (Supp. 95-1).

R9-24-412. Loan Repayments

A. Each participant shall submit to ADHS a Service Verification Form as shown in Exhibit D at the end of each quarter of service, certifying full-time, continuous service by the recipient. The form shall be signed by both the award recipient and the executive director or manager of the service site. Failure to timely submit a Service Verification Form may result in delay of payment to lenders.

B. The Department, following receipt of a participant's quarterly Service Verification Form, shall make payments to the participant's lending institutions for each quarter of service over the term of the participant's contract.

C. Award payments shall be made directly to the lending institution for each program participant. Participants shall inform their financial lending institutions of any change in the schedule of payments on their loans.

Exhibit D. Service Verification Form

Service Verification Form

This is to verify that _____has completed full-time, continuous employment in
(Loan Repayment Recipient)
good standing at _____, for the service quarter beginning _____(Practice Site)
and ending_____, as specified in the Arizona Loan Repayment Program contract executed with the Arizona Department of Health Services. This signed form is due on or before 10 business days after the last day of the completed quarter of service to assure timely payment on the recipient's education loan(s). The form shall be submitted to:

Arizona Loan Repayment Program
Office of Health Planning, Evaluation and Statistics -Rm 312
Arizona Department of Health Services
1740 West Adams Street
Phoenix, Arizona 85007

I hereby verify I have completed this service quarter as in my contract and seek payment required on my educational loans.

_____ _____
Signature of Loan Recipient Date

_____ _____
Signature of Service Site Date
Executive Director/Administrator or authorized signatory

****

State of Arizona)

County of)

The foregoing instrument was acknowledged before me this _____day of _____,_____,
by_____.

My Commission Expires:_____ _____ _____ _____
Notary Public

****

State of Arizona)

County of)

The foregoing instrument was acknowledged before me this _____day of _____,_____,
by_____.

My Commission Expires:_____
Notary Public

========== FOR OFFICE USE ==========

Contract No._____Quarterly Payment Amount $

Approved for Payment by_____Date:

Historical Note
Adopted effective March 17, 1995 (Supp. 95-1).

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES EMERGENCY MEDICAL SERVICES

(Authority: A.R.S. §§ 36-136(F) and 36-2209(A) *et seq*.)

Editor's Note: This Chapter contains rules which were adopted, amended, and repealed under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 36-2205 (C). Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is being printed on blue paper.

ARTICLE 1. DEFINITIONS

Article 1, consisting of Section R9-25-101, adopted effective October 15, 1996 (Supp. 96-4).

Section
R9-25-101. Definitions

ARTICLE 2. ADVANCED LIFE SUPPORT BASE HOSPITAL CERTIFICATION

Article 2, consisting of Sections R9-25-201 through R9-25-213 and Exhibits A through B, adopted effective October 15, 1996 (Supp. 96-4).

Section
R9-25-201. General Requirements
R9-25-202. Application Procedure
Exhibit A. Advanced Life Support Base Hospital Application for Certification/Recertification
R9-25-203. Denial of Application
R9-25-204. Amendment of the Certificate
R9-25-205. Transfer of Certificate
R9-25-206. Base Hospital Authority and Responsibilities
Exhibit B. Repealed
R9-25-207. Medical Director
R9-25-208. Prehospital Manager
R9-25-209. Base Hospital Physician
R9-25-210. Nurse Intermediary
R9-25-211. Required Records, Reports, and Notifications
R9-25-212. Department Oversight
R9-25-213. Letter of Censure, Probation, Suspension, Revocation of Certificate

ARTICLE 3. BASIC LIFE SUPPORT TRAINING PROGRAM CERTIFICATION

Article 3, consisting of Sections R9-25-301 through R9-25-311 and Exhibits C through F and H, adopted effective October 15, 1996 (Supp. 96-4).

Section
R9-25-301. BLS Training Program Certificate
R9-25-302. Operating Authority
R9-25-303. Medical Director
R9-25-304. BLS Training Program Director
R9-25-305. Instructor
Exhibit F. Instructional Strategies for EMS Instructors
R9-25-306. Preceptor Qualifications
R9-25-307. BLS Training Program Course Requirements
Exhibit H. Basic EMT - Special Skills Vehicular Rotation Requirements
R9-25-308. Trainee Prerequisites
R9-25-309. Disclosure Documents
R9-25-310. Quality Management Program
R9-25-311. Letter of Censure, Probation, Suspension, Revocation of Certificate
Exhibit D. BLS EMS Training Program Equipment/Supplies List
Exhibit C. Basic Life Support Training Program Application for Certification/Recertification/Course Approval
Exhibit E. BLS Training Program Course Completion Report

ARTICLE 4. ALS TRAINING PROGRAM CERTIFICATION EMT-INTERMEDIATE AND EMT-PARAMEDIC

Article 4, consisting of Sections R9-25-401 through R9-25-411 and Exhibits I through K, adopted effective October 15, 1996 (Supp. 96-4).

Section
R9-25-401. ALS Training Program Certificate
R9-25-402. Operating Authority
R9-25-403. Medical Director
R9-25-404. ALS Training Program Director
R9-25-405. Course Manager
R9-25-406. Faculty and Preceptor Qualifications
R9-25-407. ALS Training Program Course Requirements
R9-25-408. Trainee Prerequisites
R9-25-409. Disclosure Documents
R9-25-410. Quality Management Program
R9-25-411. Letter of Censure, Probation, Suspension, Revocation of Certificate
Exhibit I. ALS Training Program Application for Certification/Recertification/Course Approval
Exhibit J. ALS EMS Training Program Equipment/Supplies List
Exhibit K. ALS Training Program Course Completion Report

ARTICLE 5. BASIC LIFE SUPPORT CERTIFICATION

Article 5, consisting of Sections R9-25-501 through R9-25-515 and Exhibit P, adopted effective October 15, 1996 (Supp. 96-4).

Section
R9-25-501. Certification Application Requirements
R9-25-502. Applicant Screening Process
R9-25-503. Denial of Application
R9-25-504. Examinations for Initial Certification
R9-25-505. Duration of Certification
R9-25-506. Out-of-state Applicants
R9-25-507. Applicants with Disabilities
R9-25-508. Scope of Practice
R9-25-509. Special Skills Certification
R9-25-510. Recertification Requirements for EMT-Basic
Exhibit P. Recommendation for BLS Recertification
R9-25-511. Recertification for EMT-Basic Special Skills
R9-25-512. Extension of Recertification Applicant Requirements
R9-25-513. Inactive Status Due to Temporary Medical Condition
R9-25-514. Reporting Requirements
R9-25-515. Enforcement Actions

ARTICLE 6. ADVANCED LIFE SUPPORT

CERTIFICATION

Article 6, consisting of Sections R9-25-601 through R9-25-616 and Exhibits L through O and Q through S, adopted effective October 15, 1996 (Supp. 96-4).

Section
R9-25-601. Certification Application Requirements
R9-25-602. Applicant Screening Process
R9-25-603. Denial of Application
R9-25-604. Examinations for Initial Certification
R9-25-605. Duration of Certification
R9-25-606. Out-of-state Applicants
R9-25-607. Applicants with Disabilities
R9-25-608. Scope of Practice
R9-25-609. Extended Scope of Practice Training Requirements
Exhibit R. Immunization Training Practical Evaluation Form
R9-25-610. Paramedic Recertification Requirements
R9-25-611. Intermediate Recertification Requirements
R9-25-612. Extension of Recertification Application Requirements
R9-25-613. Inactive Status Due to Temporary Medical Condition
R9-25-614. Downgrading of Certification
R9-25-615. Reporting Requirements
R9-25-616. Enforcement Actions
Exhibit S. Verification of ALS Recertification Requirements
Exhibit G. Class Roster
Exhibit L. Emergency Medical Technician Original Certification Application
Exhibit M. Physical Verification Form
Exhibit N. Criminal History Disclosure for EMT Certification Application
Exhibit O. Emergency Medical Technician Recertification Application
Exhibit Q. Application for Extension of Certification

ARTICLE 7. RESERVED

ARTICLE 8. MEDICAL DIRECTION PROTOCOLS FOR EMERGENCY MEDICAL TECHNICIANS

Article 8, consisting of R9-25-801, R9-25-802, Exhibits 1 through 4, and R9-25-803 Exhibit 1, recodified from A.A.C. R9-13-1501, R9-13-1502, Exhibits 1 through 4, and R9-13-1503 Exhibit 1; originally filed under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 98-1).

Article 8, consisting of Section R9-25-805 and Exhibits 1 through 3, adopted effective May 19, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6; filed in the Office of the Secretary of State May 21, 1997 (Supp. 97-2).

Section
R9-25-801. Protocol for Administration of Immunizations by Advanced Life Support Personnel
R9-25-802. Level of Care
Exhibit 1. Immunization Screening Information-Immunization Program
Exhibit 2. Immunization Brochures and Forms
Exhibit 3. Consent For Immunization
Exhibit 4. Vaccine Administration
R9-25-803. Protocol for Drug Box Procedures
Exhibit 1. EMT-P Drug List; EMT-I Drug List
Exhibit 2. Intravenous Infusions to be Monitored by Appropriate Level of EMT Personnel
R9-25-804. Reserved
R9-25-805. Protocol for IV Access by EMT-Basics
Exhibit 1. Lecture/Lab Vascular Access for EMT-Basics
Exhibit 2. Course Outline
Exhibit 3. IV QA Form

ARTICLE 1. DEFINITIONS

R9-25-101. Definitions (Authorized by A.R.S. §§ 36-2202(A), (2), (3), (4), and 36-2204(1)-(7))

In Articles 2 through 6 of this Chapter, unless the context otherwise requires:

1. "Active course roster" means a roster submitted to the Department upon completion of a screening process which indicates all students enrolled in the course.
2. "Addendum roster" means an official course roster submitted to the Department after the official course completion date to add the names of students who completed clinical or vehicular requirements after the official course completion date.
3. "Administrative medical direction for ALS personnel" means supervision of prehospital providers by the base hospital medical director.
4. "Administrative medical direction for EMT-Basic" means supervision of EMT-Basic prehospital providers by a base hospital medical director or basic life support medical director.
5. "Advanced cardiac life support" or "ACLS" means invasive, pharmacologic, or mechanical electrical cardiovascular care.
6. "Advanced cardiac life support instructor" or "ACLS instructor" means an individual who has successfully completed an American Heart Association Advanced Cardiac Life Support Instructor Course and holds a current instructor's card.
7. "Advanced cardiac life support provider" or "ACLS provider" means an individual who has successfully completed an advanced cardiac life support provider course and has demonstrated competency in rhythm interpretation, advanced airway management, peripheral and central intravenous lines, and pharmacologic and mechanical electrical dysrhythmia therapy.
8. "Advanced life support" or "ALS" means those medical treatments, procedures, including assessment, and techniques which may be administered or performed by ALS personnel established pursuant to A.R.S. § 36-2205.
9. "Agency" means an organization that provides prehospital emergency medical services.
10. "ALS personnel" means a paramedic or an intermediate certified under Article 6 of this Chapter.
11. "Basic cardiac life support" or "BCLS" means non-invasive external cardiovascular care.
12. "Basic cardiac life support instructor" or "BCLS instructor" means an individual who has successfully completed a basic cardiac life support instructor course and holds a current instructor's card issued by the American Heart Association, American Red Cross, Red Cresent Association of Canada, National Safety Council, Medic First Aid, or the Save-a-Life Foundation of Tucson, Arizona.
13. "Basic life support" or "BLS" means those medical treatments, procedures, and techniques which may be administered or performed by emergency medical technicians.
14. "Basic life support medical director" means a physician licensed pursuant to A.R.S. Title 32, Chapter 13 or 17, in good standing, who provides administrative medical direction to basic emergency medical technicians.
15. "Challenge course" means a course that prepares and enables specified individuals to apply for and take certification exams in Arizona without repeating an entire training course.
16. "Clinical" means providing direct patient care.
17. "Competency" means ability to perform a skill to the standard of care.
18. "Communication protocols" means written guidelines that provide:
    a. The circumstances and patient conditions which require on-line medical direction, off-line medical direction, or predetermined medical direction;
    b. The facility which will exercise on-line medical direction for a given emergency; and
    c. Backup procedures for communications equipment failure.
19. "Conference/Didactic/Lecture session" means a continuing medical education presentation by an individual or a presentation utilizing printed, electronic, or audiovisual media that incorporates a post training assessment.
20. "Continuing education" means a planned, organized learning experience designed to build upon the educational and experiential bases to enhance practice, education, administration, or research to improve health care to the public.
21. "Current status" means successful completion of a course in advanced cardiac life support or basic cardiac life support training every 2 years.
22. "Department" means the Department of Health Services.
23. "Designed to exclude bias" means a process that prevents discrimination against individuals based on age, race, religion, sex, ethnic or national origin, or disability.
24. "Direct communications" means information and medical direction conveyed by person-to-person, 2-way radio, or telephone conversation.
25. "Distractors" means incorrect answers incorporated into multiple choice test design.
26. "Documented" means a written record.
27. "Emergency medical patient" means an individual who may require immediate prehospital assessment, treatment, transportation, or evaluation by a physician.
28. "Emergency medical service patient contacts" means patients received by a hospital from an EMS agency or patients on whom a field incident report form or first care form was initiated.
29. "EMS" means emergency medical services.
30. "EMSCOM" means the emergency medical services communications system operated by the Department of Public Safety.
31. "EMT" means Emergency Medical Technician, including:
    a. Paramedics (EMT-P),
    b. Intermediate Emergency Medical Technicians (EMT-I), and
    c. Basic Emergency Medical Technicians (EMT-B).
32. "Enrolled" means accepted and registered in a course.
33. "Field experience" means prehospital assessment and treatment of patients.
34. "Field incident report form" or "first care form" means a record of emergency response activities, completed by an EMT, that includes documentation of the prehospital patient assessment, treatment, and transportation if a transport occurs.
35. "Good standing" means current and valid certification or licensure, that is not under order of probation, suspension, or revocation.
36. "Health care provider" means an individual licensed or certified to render medical care to a patient.
37. "Indirect communications" means information and medical direction conveyed by an intermediary from within a certified ALS Base Hospital.
38. "Instructor intern" means an individual who assists an instructor in teaching in an EMT Training Program

course and assumes, under direct supervision, the instructional and administrative functions of the course.

39. "Local EMS coordinating system" means an agency responsible for the coordination of a regional EMS system pursuant to A.R.S. § 36-2210.
40. "Medical direction authorities" means a physician, nurse intermediary, physician's assistant, or nurse practitioner, who has attended the base hospital physician's orientation and is designated by the base hospital medical director to render on-line medical direction to prehospital EMS personnel from within a certified ALS Base Hospital.
41. "Multimedia instruction" means learning activities which have media-based format, computer-based format, or ongoing serial productions, and which have an evaluative process that has been approved by the participant's medical direction authority.
42. "Official course end date" means the last scheduled day of classes as identified in the course schedule submitted to the Department pursuant to the requirements of Articles 3 or 4 of this Chapter.
43. "Official course roster" means a list of all students who successfully complete a training program course.
44. "Off-line medical direction" means development and approval, by the base hospital medical director, of written treatment protocols which comply with A.R.S. § 36-2205, that authorize prehospital providers to render patient care without on-line medical direction.
45. "On-line medical direction" means supervision of prehospital EMS personnel by medical direction authorities through direct or indirect communications from a certified ALS Base Hospital.
46. "Pediatric advanced life support provider" means an individual who has successfully completed a pediatric advanced life support provider course and has demonstrated competency in pediatric rhythm interpretation, advanced airway management, peripheral and central intravenous lines, intraosseous infusion, thoracostomy, and pharmacologic and electrical dysrhythmia therapy.
47. "Personal relationship" means a spouse, child, grandchild, parent, grandparent, brother, or sister of the whole or half blood and their spouse, and the parent, brother, or sister of the spouse.
48. "Predetermined medical direction" means development and approval of written protocols by a regional council developed in compliance with A.R.S. § 36-2205, including training and quality assurance components, and made available to the base hospitals.
49. "Prehospital case reviews" means continuing education conducted by the ALS Base Hospital under the direction of the base hospital medical director and ALS Base Hospital prehospital manager for the purpose of reviewing and evaluating patient care, and educational and administrative requirements of the prehospital providers assigned to the ALS Base Hospital.
50. "Prehospital provider" means emergency medical technicians and individuals licensed or certified to render on-scene emergency medical care.
51. "Standing orders" means written orders which authorize prehospital personnel to render certain treatment modalities prior to initiation of direct communication with the ALS Base Hospital.
52. "Supervised clinical training" means documented experience of an EMT which details the EMT's in-hospital patient care performance supervised by a physician, emergency nurse, or another EMT at the same or higher level of certification.
53. "Supervised vehicular training" means documented experience of an EMT which details the EMT's prehospital patient care performance supervised by a vehicular preceptor.
54. "Tardiness" means arriving after the designated starting time.
55. "Trauma patient management" means a competency based course in prehospital emergency care that includes training in prehospital emergency scene management, trauma patient assessment and treatment, triage standards, emergency transportation criteria, communication, documentation, mechanism of injury, trauma airway management, and shock resuscitation.
56. "Treatment protocols" means prehospital guidelines for utilizing treatments which are adopted pursuant to A.R.S. § 36-2205.
57. "Triage protocols" means prehospital guidelines for the selection of an emergency receiving facility to which emergency patients are transported.
58. "Vehicular preceptor" means a person acting as an agent of a base hospital or training program to observe, evaluate, supervise, or assist EMTs in the performance of skills during vehicular training.
59. "Vehicular preceptor experience" means observing, evaluating, supervising, or assisting EMTs in the performance of skills during vehicular training.
60. "Vehicular ride-along experience" means experience on an emergency vehicle unit to gain prehospital experience and observe the prehospital environment, operational procedures, and performance of EMTs.
61. "Verification" or "verified statement" means a signed document that verifies the validity of statements or claims.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

ARTICLE 2. ADVANCED LIFE SUPPORT BASE HOSPITAL CERTIFICATION

R9-25-201. General Requirements (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(6))

A. Each certificate for an advanced life support base hospital shall contain the name and address of the health care institution, health care institution administrator, base hospital medical director, prehospital manager, and the expiration date.

B. The certificate shall be conspicuously posted in the base hospital.

C. The certificate is valid only for the location identified on the certificate.

D. Each base hospital certificate shall be the property of the Department and shall be returned to the Department immediately upon suspension or revocation of the certificate, or upon termination of base hospital services by the health care institution indicated on the certificate.

E. A certificate is valid for a period of 2 years provided the base hospital complies with the standards established in this Article.

F. The health care institution shall immediately notify the Department if it receives notice of Medicare termination or a life safety code violation, or is issued a provisional license.

G. The base hospital shall not operate without a medical director and prehospital manager who meet the qualifications established in these rules.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-202. Application Procedure (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(5) and (6))

A. Application for certification and recertification shall be made on a form provided by the Department as shown in Exhibit A. Submission of the application shall constitute permission for a representative from the Division of Emergency Medical Services to audit the applicant's qualifications, as established in this Article.

B. Initial application: The applicant shall submit the following documentation to the Department with the initial application form:

1. A copy of its current Arizona health care institution license;
2. Written endorsement of the application by the hospital's governing board or board of trustees;
3. The curriculum vitae of the base hospital medical director;
4. The curriculum vitae of the prehospital manager;
5. A list of all base hospital physicians, nurse intermediaries, physician's assistants, and nurse practitioners responsible to provide prehospital medical direction;
6. A letter of intent between the applicant and an agency that employs emergency medical technicians, who require medical direction, for the applicant to serve as the agency's base hospital after certification is obtained;
7. A verified statement that the applicant shall assure the physical presence of a base hospital physician in the hospital, to be immediately available to the emergency department to provide on-line medical direction 24 hours a day, 7 days a week;
8. In regions in which a local emergency medical services coordinating system operates, the applicant may request and submit a written recommendation for certification as a base hospital from the local emergency medical services coordinating system.

C. Recertification application

1. The applicant shall submit the recertification application to the Department at least 60 days prior to the expiration date of its current certificate.
2. The applicant shall submit the following documents with the recertification application form:
   a. A copy of its current license as a health care institution;
   b. Written endorsement of the application by the hospital's governing board or board of trustees; and
   c. Written verification that the information contained in subsections (B)(3) through (7) remains unchanged; or, documents required by subsections (B)(3) through (7) that have changed since submission of the last certification application.

D. Department Audit: Subsequent to the submission of an application for certification or recertification, the Department shall conduct an audit according to the following procedures:

1. The Department shall verify that the agreements, policies, procedures, plans, programs, equipment, and standards required by R9-25-206 are in place and satisfy the requirements of the rule and that the equipment is operational;
2. The Department shall verify that the information contained in the application and that the base hospital staff meet the requirements and qualifications of this Article;
3. The Department shall notify the applicant in writing of any deficiencies;
4. The applicant shall correct any deficiencies within 30 days of receipt of the Department's written notice of deficiencies;
5. The applicant shall submit to a re-audit to verify correction of deficiencies at the discretion of the Department.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT A

Arizona Department of Health Services
Emergency Medical Services

Advanced Life Support Base Hospital
Application for Certification/Recertification

Name of licensed health care facility applying for certification:

_____

Address of the facility:

_____

Address

_____

City County Zip

Administrator's name and phone number:

_____

Name Phone number

Base Hospital Medical Director's name and phone number:

_____

Name Phone number

Prehospital Manager's name and phone number:

_____

Name Phone number

I hereby verify that: (1) All information contained on this application and supporting documentation is true and accurate; (2) I have the authority to act on behalf of, and legally bind, the named agency as applicant; (3) All documentation as required in *Arizona Administrative Code* R9-25-202 are attached hereto.

Signature _____ Title _____ Date _____

Historical Note
Exhibit A adopted effective October 15, 1996 (Supp. 96-4).

R9-25-203. Denial of Application (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(5) and (6))

The director shall deny the application if the applicant:

1. Failed to conform to the requirements of this Chapter;
2. Filed information that could not be verified.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-204. Amendment of the Certificate (Authorized by A.R.S. §§ 36-2202(A)(3) and (4) and 36-2204(6))

A. The base hospital shall submit to the Department a written request to amend its certificate after a change of address, change in health care institution administrator, base hospital medical director, or prehospital manager. The request shall be received by the Department no more than 30 days after the change has occurred.

B. The application shall include:

1. For a change of address, notification of the new address and the effective date of the relocation;
2. For a change in health care institution administrator, the name of the new administrator and the effective date of employment;
3. For a change in base hospital medical director or prehospital manager, the name of the new medical director or prehospital manager, a curriculum vitae, and the effective date of employment.

C. The Department shall issue an amended certificate upon notification of a change of address or change of health care institution administrator. The Department shall issue an amended certificate containing the name of the new medical director or prehospital manager provided the candidate satisfies all required qualifications.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-205. Transfer of Certificate (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(5) and (6))

A. The health care institution may transfer the base hospital certificate if ownership of the institution changes. The transferee shall not begin operation as a base hospital until it receives written notice from the Department that the transfer is approved.

B. The health care institution shall submit an application to the Department, at least 60 days prior to the date on which the transfer will occur, that contains:
1. The name of the transferee;
2. The date of the proposed transfer;
3. Verification that the health care institution administrator, base hospital medical director, and prehospital manager shall remain the same; or, the names of the new administrator, base hospital medical director, and prehospital manager, and a curriculum vitae of the new medical director and prehospital manager; and
4. Verification from the transferee that it has received and shall comply with the rules governing the base hospital operation.

C. The Department shall transfer the certificate without a hearing if the application is complete and the medical director and prehospital manager satisfy the qualifications established in this Article. The certificate shall expire on the expiration date of the certificate that was transferred.

D. The Department shall deny an application that is incomplete or if the medical director or prehospital manager do not satisfy the qualifications established in this Article. The applicant may request a hearing to have the denial reviewed. The request shall be made in writing and shall be filed with the Department's Office of Administrative Counsel within 30 days of receipt of denial.

E. The health care institution may correct the deficiencies identified and may resubmit an application to transfer a certificate.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4).

The following Section was amended under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 36-2205 (C). Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register as proposed rules; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings on this Section (Supp. 98-4).

R9-25-206. Base Hospital Authority and Responsibilities (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(5) and (6))

A. A certified base hospital shall provide:
1. Administrative medical direction to emergency medical technicians who require medical direction;
2. On-line medical direction to emergency medical technicians who require medical direction;
3. Continuing education that meets the standards established in R9-25-510, R9-25-610, and R9-25-611. Prior Department approval is not required.

B. A certified base hospital may:
1. Provide advanced skills training and ALS and BLS refresher training if it meets the standards established in subsection (I).
2. Utilize nurse intermediaries according to the standards established in R9-25-210.

C. Supporting Service Agreement: The Base Hospital shall execute a written contract with an agency which employs emergency medical technicians in a prehospital setting. The contract shall:
1. Require the base hospital to provide both administrative and on-line medical direction to the prehospital emergency medical technicians who are employed by the agency.
2. Be reviewed and updated yearly. The base hospital shall maintain written verification that the yearly review and update was performed.
3. Contain an addendum or exhibit that lists the name of each emergency medical technician assigned to the base hospital.
4. Require the agency to verify that only emergency medical technicians with current certification are assigned to the base hospital.
5. Require the agency to notify the base hospital in writing within 30 days of any termination or transfer of an emergency medical technician, or of any addition of an emergency medical technician to the base hospital for medical direction. The notification shall include the name, certification expiration date of the emergency medical technician, and the effective date of employment, transfer, or termination.
6. Establish a procedure to replace disposable, medical, and pharmaceutical supplies for the contracted provider agency after patient care has been terminated by the agency.
7. Contain a provision that assures the disposal of contaminated waste meets federal and state requirements.
8. Contain a provision that adopts a conflict resolution procedure specific to the agency that:
   a. Investigates and resolves patient, physician, prehospital manager, and nurse intermediary complaints about the agency, its procedures, and agency personnel; and,
   b. Investigates and resolves agency complaints about the base hospital, its procedures, the medical director, emergency physicians, nurse intermediaries, prehospital manager, or other base hospital personnel.
9. Require the agency to have working communication equipment that allows base hospital medical direction communication with emergency medical technicians in the field.
10. Contain a provision that establishes:
    a. Written procedures to withdraw or suspend medical direction;
    b. Written medical direction requirements for the emergency medical technicians; and
    c. Written procedure for notifying the employing agency and the emergency medical technician of the withdrawal or suspension of medical direction.

D. The base hospital and the agency shall jointly develop and implement:
1. Written policies and procedures that all emergency medical technicians must follow. These policies and procedures shall include:
   a. The form and content of required documentation for each emergency medical service incident;
   b. The procedures that each category of emergency medical technician must follow in patient assessment;
   c. Communication procedures for requesting, providing, and receiving medical direction;

d. A plan to provide patient outcome data to the agency with a supporting service agreement that protects confidentiality and considers budget constraints; and
e. A requirement for all prehospital medical personnel, operating under predetermined medical control and off-line medical control, to notify the receiving facility prior to arrival.

2. A written quality improvement plan that shall include:
a. At least 1 continuing quality improvement committee representative from each agency. One representative shall be from each level of certified emergency medical technicians for which the base hospital provides medical direction. The committee shall meet at least semi-annually, keep regular meeting minutes, evaluate complaints, develop continuing education courses, cooperatively work on quality management issues, and provide updates on prehospital issues which affect the base hospital or agencies with supporting service agreements with the base hospital.
b. A yearly requirement that the medical director, prehospital manager, physicians, nurses, all base hospital staff, and prehospital personnel complete a documented review of all new, modified, and deleted base hospital protocols or procedures.
c. Documented review by all medical direction authorities and prehospital personnel of all protocols and procedures which shall be done every 2 years in conjunction with the base hospital certification.
d. A system to review the following categories of prehospital patient encounters to assure that both prehospital and base hospital personnel followed established protocols and base hospital procedures:
i. Monthly random reviews of 5% of refusals to treat, to a maximum of 100 reviews per month;
ii. All code arrests;
iii. All "do not resuscitate" cases; and
iv. Monthly random reviews of 5% of advanced life support encounters, to a maximum of 1,000 reviews per year, with a minimum of 30 encounters reviewed per quarter.
e. A process and documentation procedure to develop a corrective action plan when review of cases indicates a lapse in following protocol or procedure.

3. A process for EMTs assigned to the base hospital to follow for submission of recertification applications to the base hospital prior to filing with the Department.
4. A written process for evaluating the prehospital activities of each EMT to assess the EMT's competency. The process shall require this evaluation to be completed prior to signing the application supporting recertification. The process shall also permit the base hospital medical director to elect to have the EMT-P or EMT-I pass an examination approved by the Department as a prerequisite to recertification if the medical director makes the request in writing submitted with the application. The process shall require the base hospital medical director to specify if the EMT-P or EMT-I recertification examination shall contain a written component, practical component, or both components.

E. The base hospital shall establish an orientation program for the medical director, prehospital manager, nurse intermediaries, and base hospital physicians, that includes:
1. Review of emergency medical service treatment and triage guidelines, policies, and procedures;
2. Review of communication equipment available at the base hospital;
3. Review of prehospital personnel levels of certification and treatment and patient care capabilities;
4. Review of prehospital continuing quality improvement policies;
5. Review of prehospital policy if concerns are identified or complaints are received about the base hospital;
6. Review of Department rules, protocols governing prehospital treatment, and the drug box list;
7. Review of the state and regional emergency medical service system; and,
8. Review of the base hospital continuing education requirements for nurse intermediaries and base hospital physicians employed at or assigned to the base hospital.

F. The base hospital shall:
1. Assure that all emergency physicians who provide online medical direction to prehospital personnel meet the requirements established in R9-25-209;
2. Assure that all newly appointed medical direction authorities complete the orientation program within 30 days of their appointment; and
3. Assure that all medical direction authorities document and review all updated or modified protocols on a yearly basis.

G. The base hospital shall provide the necessary communications equipment.
1. The radio equipment shall be operational and compatible with the Department of Public Safety EMSCOM communications system or a local EMS communication system with a frequency and list of channels approved by the Department of Public Safety. The base hospital shall have communications equipment approved by the Department of Public Safety and be compatible with that of the prehospital emergency medical service agency.
2. The equipment shall be operational at all times and be located in the emergency department permitting direct communication with emergency medical service personnel.
3. The base hospital shall provide a dedicated telephone line to enable emergency prehospital care personnel to contact the base hospital directly.
4. All telephone and radio communication between the base hospital and prehospital emergency medical service personnel for the purpose of medical direction shall be recorded. The recording shall be kept for a minimum of 3 months. Should the medical director or prehospital manager identify a potential problem with the prehospital provider's reporting or if a review is required according to the Continuing Quality Improvement Plan, the base hospital shall keep the tape a minimum of 24 months from the date of the potential problem or required review. The tape may be destroyed if the base hospital makes a written report of the event. The base hospital shall maintain the written report for a minimum of 24 months from the date of the potential problem or required review.
5. Requirements for the use of biotelemetry equipment may be established by the advanced life support base hospital medical director in the medical control plan for the base hospital.

H. The base hospital shall establish the following communication procedures:
1. Provisions to notify a receiving facility of an incoming patient if notification has been made to the base hospital rather than the receiving facility.

2. A written plan for alternative communications with field personnel in the event of disaster, communication equipment breakdown or repair, power outage, or malfunction.

I. The base hospital shall provide education and training.
1. The base hospital shall provide 24 clock hours of continuing education per year that may be offered over a 9- to 12-month period.
2. The courses shall follow the Department's requirements for continuing education for each level of EMT as described in Articles 5 and 6.
3. The base hospital shall provide training for any new Department approved required treatment, protocol, or drug within 90 days of receiving notification from the Department that the training has been adopted in rule.
4. The base hospital shall provide facilities, equipment, and audio-visual aids for the continuing education required by this rule.
5. The base hospital shall include prehospital case reviews in the 24 clock hours of continuing education per year. Prehospital case reviews may be incorporated into didactic or clinical skills. The base hospital shall require the review to be prepared under the direction of the prehospital manager and medical director.
6. The ALS Base Hospital may:
   a. Provide advanced training that meets the following curriculum standards approved pursuant to A.R.S. § 36-2205 and published by the Department of Health Services, Emergency Medical Services, 1651 E. Morten Avenue, Suite 120, Phoenix, Arizona 85020, incorporated by reference and on file with the Department and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments:
      i. Transcutaneous External Pacer (TEP) Procedure Training Curriculum, dated October 5, 1992; and
      ii. Administration of Rectal Valium Procedure Training Curriculum, dated October 5, 1992; and
      iii. Automatic Transport Ventilators Treatment Protocol and Training Curriculum, dated May 13, 1993; and
      iv. Intraosseous Infusion (I.O.) Procedure Training Curriculum, dated July 1, 1992; and
      v. Prehospital Blood Glucose Testing Procedure Training Curriculum, dated March 3, 1993.
   b. Provide ALS refresher training that meets the requirements of the Arizona Advanced Life Support Refresher and Challenge Curricula, dated July 22, 1994, published by and available at the Department of Health Services, Emergency Medical Services, 1651 E. Morten Avenue, Suite 120, Phoenix, Arizona 85020, incorporated by reference and on file with the Department and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments. The ALS Base Hospital shall comply with all of R9-25-403, R9-25-404(B), R9-25-406(A), R9-25-407(C),(E),(K), and (L), and R9-25-410.
   c. Provide BLS refresher training that meets the requirements of the Arizona Basic EMT Refresher Curriculum, dated July 22, 1994, published by and available at the Department of Health Services, Emergency Medical Services, 1651 East Morten Avenue, Suite 120, Phoenix, Arizona 85020, incorporated by reference and on file with the Department and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments. The ALS Base Hospital shall comply with all of R9-25-303, R9-25-304(B), R9-25-305, R9-25-307(B), (D), (H), (I), and (J), and R9-25-310.

J. Drug Control. The base hospital shall:
1. Establish a written drug box security plan and documentation system; and
2. Develop a written narcotic wastage plan.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4). Amended effective November 30, 1998; filed in the Office of the Secretary of State November 24, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) (Supp. 98-4).

The following Exhibit was repealed under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 36-2205 (C). Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit this change to the Secretary of State's Office for publication in the Arizona Administrative Register as proposed rules; the Department did not submit the change to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings on the repealing of this Exhibit (Supp. 98-4).

Exhibit B. Repealed

Historical Note
Exhibit B adopted effective October 15, 1996 (Supp. 96-4). Repealed effective November 30, 1998; filed in the Office of the Secretary of State November 24, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) (Supp. 98-4).

R9-25-207. Medical Director (Authorized by A.R.S. §§ 36-2202(A)(3), and (4), and 36-2204(5), and (6))

A. Qualifications. The medical director shall:
1. Be currently licensed in good standing in the state as a physician pursuant to A.R.S. Title 32, Chapter 13 or 17;
2. Be board certified in Emergency Medicine by the American Board of Emergency Medicine or the American College of Osteopathic Emergency Physicians; or maintain current provider status in:
   a. Advanced Cardiac Life Support;
   b. Advanced Trauma Life Support according to the American College of Surgeons Committee on Trauma; and
   c. Pediatric Advanced Life Support or American College of Emergency Physicians' pediatric advanced life support.
3. Provide a verified statement indicating at least 24 clock hours teaching experience in prehospital medicine;
4. Have at least 2,000 hours of clinical or administrative time in emergency medicine within the 24 months prior to the appointment; and
5. Not be a base hospital medical director for more than 1 health care institution simultaneously.

B. Responsibilities. The medical director shall:
1. Spend at least 2,000 hours of clinical or administrative time every 24 months in Emergency Medicine.
2. Coordinate the base hospital emergency medical services system, administrative medical direction, on-line medical direction, and administrative medical direction of the advanced life support base hospital staff.

3. Complete, within 1 month of beginning employment, the base hospital physician orientation program.
4. Every 24 months sign a verified statement that the medical director has reviewed the base hospital physician orientation program assuring that it meets with the standards of R9-25-206(E) and (F).
5. Provide at least 8 hours per year of continuing education for base hospital personnel assigned to the base hospital. This may be in didactic presentation, skills training, individual counseling about prehospital documentation, run review, patient care, patient assessment, or prehospital procedures and skills.
6. Institute protocols adopted pursuant to A.R.S. § 36-2205.
7. Assure that the prehospital manager maintains yearly written verification confirming his or her review of:
   a. Prehospital emergency medical services personnel update and of any modified policies and procedures.
   b. The medical control plan for the base hospital which includes the following:
      i. Local, regional, and state treatment protocols;
      ii. Local, regional, and state triage protocols;
      iii. Local and regional communication protocols.
8. Assure that all medical direction authorities and prehospital personnel review all protocols and procedures every 2 years in compliance with R9-25-206(D)(2)(c).
9. Review, approve, and implement the continuing quality improvement plan that meets the standards established in R9-25-206(D)(2).
10. Establish, review, approve, and implement a plan for evaluating the performance of emergency medical technicians that meets the standards established in R9-25-206(D)(3) and (4).
11. Monitor the performance of all prehospital emergency medical service personnel assigned to the base hospital to insure complete patient assessment and documentation. This review shall be conducted according to the quality improvement plan established pursuant to R9-25-206(C).

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-208. Prehospital Manager (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(5) and (6))

A. Qualifications. The prehospital manager shall:
1. Be a registered nurse currently licensed in good standing in the state.
2. Prior to appointment, have completed a course in advanced cardiac life support, and the Trauma Patient Management Curriculum, dated 1996, published by the Department of Health Services, Emergency Medical Services, 1651 E. Morten Avenue, Suite 120, Phoenix, Arizona 85020, incorporated by reference and on file with the Department and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
3. Within 6 months of appointment, shall have completed a course in pediatric advanced life support.
4. Have worked at least 2,000 hours in emergency prehospital or critical care, with at least 120 hours in the 12 months prior to appointment.
5. Have at least 24 hours of teaching experience in prehospital medicine to first responders, basic life support personnel, advanced life support personnel, nurses, or physicians within the 36 months prior to appointment.

B. Responsibilities. The prehospital manager shall:
1. Complete a course in advanced cardiac life support and pediatric advanced life support every 24 months.
2. Work at least 1,000 hours of clinical, critical care, or administrative time in emergency or prehospital nursing every 2 years.
3. Complete the base hospital orientation program within 30 days after beginning employment and yearly thereafter.
4. Maintain yearly written verification confirming review and understanding of:
   a. Prehospital emergency medical services personnel policies and procedures; and,
   b. Medical control plan for the base hospital which includes the elements established in R9-25-206(E).
5. Prepare for and participate in the review of prehospital case reviews.
6. Study and evaluate prehospital emergency medical service safety and efficacy using patient outcome data of patients treated at the base hospital.
7. Participate in establishing and coordinating the Continuing Quality Improvement Plan required by R9-25-206(D)(2).
8. Participate in establishing and coordinating the plan adopted pursuant to R9-25-206(D) to provide for recertification competency of the emergency medical service personnel assigned to the base hospital.
9. Document and review compliance with continuing education requirements of all levels of emergency medical technicians, nurse intermediaries, and base hospital physicians employed by or assigned to the base hospital.
10. Participate in local and state emergency medical service system design and development.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-209. Base Hospital Physician (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(5) and (6))

A. Qualifications. The base hospital physician shall be licensed in good standing in the state as a physician pursuant to A.R.S. Title 32, Chapter 13 or 17; and be board certified, or board eligible, in Emergency Medicine by the American Board of Emergency Medicine or the American College of Osteopathic Emergency Physicians, or maintain provider status in:
1. Advanced Cardiac Life Support;
2. Advanced Trauma Life Support according to the American College of Surgeons Committee on Trauma; and,
3. Pediatric Advanced Life Support according to the American Heart Association or the American College of Emergency Physicians.

B. Responsibilities. The base hospital physician shall:
1. Be responsible for medical direction of prehospital emergency medical technicians and base hospital staff.
2. Complete the base hospital orientation program within 30 days after beginning employment at the base hospital.
3. Sign and provide the base hospital medical director with a yearly verified statement confirming review and understanding of:
   a. State, regional, and local treatment and triage protocols;
   b. Regional and local communication protocols;
   c. The base hospital policies and procedures for prehospital personnel; and,
   d. Base hospital physician requirements.
4. Complete 24 clock hours of the requirements in R9-25-209(B)(5) within the 1st year as a base hospital physician, 12 of which shall be within the 1st 3 months after appointment.

5. Complete 24 clock hours of base hospital continuing education or vehicular experience every 24 months, in any combination of the following:
   a. Ride-along vehicular time observing prehospital care. One hour of ride-along time equals 1 hour of continuing education.
   b. Prepare and teach prehospital continuing education. Each 1 hour session of prehospital continuing education teaching equals 4 hours of continuing education.
   c. Participate in prehospital continuing education that meets the requirements of R9-25-510 or R9-25-610 or both. One hour of participation equals 3 hours of continuing education.
   d. Participation in base hospital administrative activities necessary to meet the requirements for base hospital certification pursuant to this Article. One hour of participation equals 2 hours of continuing education.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-210. Nurse Intermediary (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(5) and (6))

A. Qualifications. The nurse intermediary shall:
1. Be a registered nurse currently licensed in good standing in the state.
2. Have completed a course in advanced cardiac life support within the last 24 months prior to appointment.
3. Have completed the base hospital orientation program.

B. Responsibilities. The nurse intermediary shall:
1. Receive information from the prehospital emergency medical technicians and relay on-line medical direction from the base hospital physician to the prehospital emergency medical technicians.
2. Maintain current status as an advanced cardiac life support provider.
3. Maintain yearly written verification which confirms:
   a. Review of prehospital emergency medical services personnel policies and procedures of the base hospital.
   b. Review of medical control plan for the base hospital which includes the elements required by R9-25-206(E).
   c. Compliance with continuing education requirements of nurse intermediaries in accordance with R9-25-209(B)(4) and (5).

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-211. Required Records, Reports, and Notifications. (Authorized by A.R.S. §§ 36-2202 (A)(3) and (4), and 36-2204 (5) and (6))

The base hospital shall:
1. Maintain written verification of the base hospital's annual review of the supporting service agreements.
2. Notify the Department in writing within 30 days of executing or terminating a supporting service agreement.
3. Notify the Department in writing within 30 days of any termination, withdrawal, or suspension of medical direction from an emergency medical technician. The base hospital shall provide concurrent copies of these notifications to the affected EMT and the employing agency.
4. Verify and maintain on file documentation that the medical director, prehospital manager, base hospital physicians, and nurse intermediaries attend the base hospital orientation program required by R9-25-206(E).
5. Provide the Department with a copy of recorded prehospital communications required by R9-25-206(G) and any documentation or verification required by this Chapter if requested in writing by the Department.
6. Maintain a file documenting satisfaction of the medical director and prehospital manager qualifications listed in R9-25-207(A) and R9-25-208(A).
7. Maintain written verifications of the requirements listed in R9-25-207(A) and (B) and R9-25-208(A) and (B).

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-212. Department Oversight (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(6))

A. Issuance of the certificate granting base hospital status authorizes the Department to review, at any time, the required documents, verifications, policies and procedures, personnel qualifications, equipment, and operation of the base hospital.

B. The Department may attend, without prior notification, any continuing education session offered by the base hospital.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-213. Letter of Censure, Probation, Suspension, Revocation of Certificate (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(6) and (7))

A. The Director may issue a letter of censure, place on probation, suspend, or revoke an advanced life support base hospital certification, in whole or in part, if any of its owners or operators, officers, agents, or employees:
1. Violate any of the rules in this Article;
2. Submit information required by this Article that they knew, or should have known, was false; or
3. Refuse Department personnel the right to inspect any facility, equipment, or document as provided in this Article.

B. The Department may request an informal interview with the base hospital, if it determines that any of the events listed in subsection (A) may have occurred.

C. The Director may take the following action against the base hospital certificate if an event listed in subsection (A) is substantiated:
1. Issue a letter of censure or an order of probation; or
2. Suspend or revoke a certificate after notice and opportunity to be heard is provided according to A.R.S. Title 41, Chapter 6, Article 6 and 9 A.A.C. 1, Article 1.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

ARTICLE 3. BASIC LIFE SUPPORT TRAINING PROGRAM CERTIFICATION

R9-25-301. BLS Training Program Certificate (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(1) and (3))

A. General Requirements
1. A BLS Training Program shall obtain a certificate from the Department prior to initiating any EMT-Basic, EMT-Basic refresher, or EMT-Basic special skills training.
2. Each certificate shall contain the name of the BLS Training Program, the name of the program medical director, the mailing address of the program's administrative office, the certificate number, and the certificate expiration date.
3. The certificate shall be conspicuously posted in the program's administrative office.
4. The program shall not transfer the certificate.

5. The certificate issued to the training program shall be the property of the Department and shall be returned to the Department immediately upon suspension or revocation.
6. A certificate is valid for a period of 2 years provided that the program complies with the conditions of this Article throughout the certification period.
7. A BLS Training Program shall not conduct training without a medical director who meets the qualifications of R9-25-303. The Department shall amend and reissue a certificate upon notification of a change of training program medical director.
8. The certificate shall name only 1 agency and 1 medical director.
9. The BLS Training Program shall maintain a current certificate for the duration of all courses and for 6 months after the course completion date for all courses to which R9-25-307(I) apply.

B. Initial Certification Application

1. A BLS Training Program applying for initial certification shall submit the following documents to the Department at least 45 days prior to the projected commencement date of a course:
   a. An application for certification on a form provided by the Department as shown in Exhibit C, which shall be signed by an individual with authority to act on behalf of and legally bind the named agency as applicant.
   b. A copy of all agreements with institutions for use of facilities, use of equipment, and for training. All agreements shall be in writing and signed by the authorized agent for the BLS Training Program and the institution or service.
   c. A copy of all agreements with ambulance or rescue services for vehicular training when the training program offers special skills training.
   d. A curriculum vitae for the training program medical director and training program director.
   e. A list of all instructors to include the following: name, contact telephone number, and instructor number issued by the Department.
   f. A copy of disclosure documents required by R9-25-309.
   g. A list of medical equipment owned or leased by the BLS Training Program that meets the quantity specified in the BLS Training Program Equipment List, as shown in Exhibit D.
   h. An inventory of medical supplies identified in the BLS Training Program Equipment List, as shown in Exhibit D, in sufficient quantities to enable each student to successfully accomplish the lesson objectives. The BLS Training Program shall assure that each student has adequate personal protection to meet OSHA and CDC standards for Body Substance Isolation, described in Bloodborne Pathogens 29 C.F.R. § 1910.1030, amended July 1, 1995, and §§ II and IV of "Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public-Safety Workers," published by the U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Atlanta, Georgia, February 1989. Both documents are incorporated by reference and on file with the Department and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
   i. A certificate of insurance from a company licensed to do business in the state or proof of self insurance for $500,000 malpractice and $500,000 liability protecting students, instructors, and training facilities. The BLS Training Program shall maintain this insurance or proof of self insurance during the term of its training program certificate.
   j. Copies of behavioral objectives for clinical rotations for all courses that comply with the curriculum requirements in R9-25-307(E) and behavioral objectives for vehicular rotations for special skills courses that comply with the curriculum requirements in R9-25-307(I)(4).
2. The Department shall not accept an incomplete application and shall return the incomplete application to the applicant for completion and resubmission.
3. The BLS Training Program shall not begin training students until the certificate is issued.

C. Amendment of Certificate

1. The BLS Training Program shall notify the Department within 5 working days if its medical director resigns, is terminated, or is otherwise unable to perform the duties required under R9-25-303(B).
2. The BLS Training Program shall file a written request with the Department to have its certificate amended upon the change of the training program medical director.
3. The request shall include:
   a. The name of the new medical director,
   b. A copy of the new medical director's curriculum vitae.
4. The BLS Training Program shall cease training until a new medical director is appointed who meets the qualifications of R9-25-303 and receives written approval by the Department. The Department shall then issue an amended certificate.

D. Renewal of Certificate

1. An applicant for a BLS Training Program shall submit an application for recertification to the Department at least 45 days prior to the expiration of its current certificate, on a form provided by the Department and shown in Exhibit C.
2. The application shall contain the documents identified in subsection (B)(1) that were amended, revised, or added since initial certification; or, a written verification that revised documents are not submitted because the information submitted with the initial application is unchanged.
3. An applicant for BLS Training Program recertification shall have conducted at least 1 EMT-Basic or EMT-Basic refresher course during the previous certification period.
4. A BLS Training Program which instituted a corrective action plan or is on probation may apply for renewal of its certificate. The Director may issue a renewal certificate and order that the BLS Training Program complete the terms of the corrective action plan or probation as a condition of the issuance of the renewal certificate.

E. Denial of Application

1. The Department shall deny an application that does not meet the requirements for initial certification or renewal.
2. The Director may deny an initial or renewal application for a BLS Training Program certificate if any of its owners or operators have held a previous certificate and any of them, or any of their officers, agents, or employees:
   a. Intentionally violated any of the rules in this Article.

b. Knowingly committed, aided, permitted, or abetted the commission of any crime involving medical or health related services.
c. Submitted to the Department information required by this Article that they knew, or should have known, was false.
d. Refused Department personnel access to inspect facilities, equipment, or required documents.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-302. Operating Authority (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(1) and (3))
Scope: A BLS Training Program may conduct EMT-Basic, EMT-Basic refresher, and EMT-Basic special skills courses.
1. A BLS Training Program shall make all notifications and maintain all documentation required by R9-25-307 or R9-25-304(B)(5) separately for each course.
2. The BLS Training Program shall not allow students to transfer between courses of different levels.
3. The BLS Training Program may allow students to attend didactic presentations in another course running concurrently as long as the total number of students attending the didactic presentation is in compliance with R9-25-307(B)(2)(a).
4. Clinical and vehicular rotations shall be conducted utilizing institutions, agencies, and preceptors that are currently licensed or certified in the state.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-303. Medical Director (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(1) and (3))
A. The medical director of a BLS Training Program shall have the following qualifications:
1. Be licensed as a physician pursuant to A.R.S. Title 32, Chapter 13 or 17, in good standing, in the state and maintain licensure for the term of the training program certificate.
2. Be board certified by the American College of Emergency Physicians or the American College of Osteopathic Emergency Physicians, or hold current status in advanced cardiac life support and have worked a minimum of 2,000 clinical hours in the emergency department of a licensed health care institution.

B. The medical director of a BLS Training Program shall be responsible for the following:
1. Review and approve, in writing, that the course outlines and lesson plans are consistent and do not exceed the scope of practice as contained in subsections (B)(1)(a) and (b).
   a. Arizona Basic Life Support Curriculum, dated July 22, 1994, published by and available at the Department of Health Services, Emergency Medical Services, 1651 E. Morten Avenue, Suite 120, Phoenix, Arizona 85020, incorporated by reference and on file with the Department and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
   b. Special Skills Curriculum, dated July 22, 1994, published by and available at the Department of Health Services, Emergency Medical Services, 1651 E. Morten Avenue, Suite 120, Phoenix, Arizona 85020, incorporated by reference and on file with the Department and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
2. Complete and sign the BLS Training Program Course Completion Report as shown in Exhibit E, verifying course completion and skill competency for all students completing the course.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-304. Basic Life Support Training Program Director (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(1)and (3))
A. The BLS Training Program director shall have the following qualifications:
1. Be currently licensed or certified for a minimum of 1 year and in good standing in the state as a physician, registered nurse, or EMT at any level and maintain licensure or certification for the term of the training program certificate.
2. Demonstrate and maintain at least 1,000 hours of clinical experience or 80 hours teaching experience as a physician, registered nurse, or EMT at any level, in prehospital care, emergency medicine, or critical care within the last 2 years.

B. The BLS Training Program director shall be responsible for the following:
1. Schedule classes, instructors, preceptors, facilities, clinical and vehicular rotations, and equipment for each class.
2. Assure that classes and clinical and vehicular rotations are conducted as scheduled and adhere to the lesson plans and objectives and all requirements in R9-25-307.
3. Assure that instructors and equipment are present at each class.
4. Establish policy and procedures for all BLS Training Program courses which, at a minimum, shall include:
   a. Attendance
      i. Absences and tardiness shall not exceed 16 hours.
      ii. The information and learning materials presented in the didactic portion of the program shall be made up under the direction of the instructor through individual instruction or documented self study projects. This shall not constitute exemption from the requirement of subsection (B)(4)(a)(i).
      iii. Clinical and vehicular absences and tardiness shall be rescheduled either prior to the official course completion date or consistent with the time limits in R9-25-307(G). A student shall arrange to make up clinical and vehicular absences or tardiness through the program director. Rescheduling of clinical and vehicular absences under this requirement shall not apply to the requirement of subsection (B)(4)(a)(i).
      iv. Students who contract a contagious disease identified in R9-25-309(12) during the course shall not participate in didactic, clinical, or vehicular activities until they provide written documentation from their physician that they are no longer contagious. If all absences, without regard to reason, exceed 16 didactic hours, the student shall not be eligible to complete the course.
   b. Grading - The program shall establish a grading policy that requires a minimum score of no less than 75% proficiency in didactic and 80% proficiency in practical skills testing.

5. Require and maintain the following records that contain the certificate number of the BLS Training Program and the names of the medical director and training program director:
   a. Attendance logs that include the class title, location, date, length of lecture, and the name of each student who attended the lecture.
   b. A gradebook for each course that includes each student's grades for all exams, projects, and evaluations. The gradebook shall indicate if a student dropped, withdrew, or was issued an incomplete.
   c. Clinical rotation logs for each student rotation that include the student's name and clinical area, signed and dated by the training program coordinator. For special skills courses, the logs shall contain the student's name, clinical area, a description of the skills completed by the student, and shall be signed and dated by the preceptor responsible for the rotation.
   d. Vehicular logs for each student's rotation in special skills courses that include the student's name, agency's name, unit number, field incident number, a description of skills completed by the student, and identification of each call as BLS or ALS. The logs shall be signed and dated by the preceptor responsible for the rotation.
   e. All examinations taken and graded in each class.
   f. A course schedule that includes the location, date, time, topic, duration, and instructor for each class.
   g. Skills evaluation sheets required by R9-25-307(C)(4).
   h. For special skills courses, a copy of the EMS field incident report forms completed and signed by the student or preceptor and co-signed by the student and preceptor for all patient assessments, medical care, communications, or treatments provided by the student.
   i. For special skills courses, performance evaluations for each student completed and signed by the training program director or instructor responsible for the course and the student. These evaluations shall be conducted at least once during the course and shall include: the student's name, date of evaluation, attendance record, grades, areas of proficiencies and deficiencies, and a plan for improvement, if deficiencies were noted.
   j. Assigned written projects.
   k. Instructor evaluation forms completed by students for each course instructor teaching over 10 hours.
   l. Lesson Plans that cover the objectives in the Arizona Basic Life Support Curriculum, dated July 22, 1994, previously incorporated by reference at R9-25-303(B)(1)(a); and Special Skills Curriculum, dated July 22, 1994, previously incorporated by reference at R9-25-303(B)(1)(b).
6. Complete the BLS Training Program Course Completion Report as shown in Exhibit E, verifying course completion and skill competency for all students completing the course.
7. Within 10 working days after completion of each course, submit to the Department an official course roster and a course completion report on forms provided by the Department as shown in Exhibits K and L. The course roster shall contain only the names of students that complete all didactic and clinical requirements outlined in the Arizona Basic Life Support Curriculum, dated 1994, previously incorporated by reference at R9-25-303(B)(1). The BLS Training Program may submit addendum rosters after the official course completion date for students who complete all requirements within 6 months after that date.
8. For Specialized Skills courses, the course roster shall contain only the names of students that complete all didactic, clinical, and vehicular requirements outlined in Special Skills Curriculum, dated July 22, 1994, previously incorporated by reference at R9-25-303(B)(1)(b).
9. Prepare or review a written evaluation of each student and instructor at least once during a course.
10. Assist each student in completing the application process as necessary for the state and National Registry certification examinations.
11. Coordinate and schedule the National Registry Examination in compliance with The National Registry of Emergency Medical Technicians EMT-Basic Practical Examination Users Guide, undated, published by The National Registry of Emergency Medical Technicians, 6610 Busch Blvd., P.O. Box 29233, Columbus, Ohio 43229. The entire Users Guide is incorporated by reference and on file with the Department and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
12. Analysis of certification examination results: The BLS Training Program shall maintain a cumulative pass/fail ratio of 70% of all students taking the certification examination.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-305. Instructor (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(1) and (3))

A. Each BLS course shall be taught by an instructor or team of 2 instructors who meet the following qualifications:
   1. Hold current licensure or certification in the state as a physician, registered nurse, or EMT at any level.
   2. Maintain current BCLS instructor status for EMT-Basic.
   3. Have successfully completed a course in advanced cardiac life support within the preceding 24 months and every 24 months thereafter.
   4. Have at least 500 hours of clinical experience or 40 hours teaching experience as a physician, registered nurse, or EMT at any level in prehospital care, emergency medicine, or critical care within the last 2 years.
   5. Complete an EMT instructional strategies program equivalent to the requirements of Instructional Strategies for EMS Instructors, as shown in Exhibit F.
   6. Have served as an instructor intern for 1 complete BLS training course at the level which they will instruct.

B. The Instructor shall be responsible for the following:
   1. Assure adherence to the lesson plans and objectives of the didactic portion of the course by attending all didactic and skills presentations.
   2. For special skills courses, meet with the department head of the institution and service which provides the clinical and vehicular rotations, prior to beginning the rotation, to provide and review the behavioral objectives and preceptor qualifications, and responsibilities for each rotation.
   3. Collect and forward documents required under R9-25-304(B)(5) to the training program director.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT F

ARIZONA DEPARTMENT OF HEALTH SERVICES EMERGENCY MEDICAL SERVICES

Instructional Strategies for EMS Instructors

Course Description:

This course is designed to prepare and make eligible the participant to gain approval from the Office of EMS as a Basic EMT instructor.

This course will provide detailed information on requirements by the Office of EMS for conducting a Basic EMT course, instructing in a Basic EMT course, submission of paperwork, and certification of students. Also, this course offers a general overview of educational theories and principles. It is not possible, in a short course like this, to provide all the information one needs to be an instructor. Therefore, it is important that the participants have some requisite experience in conducting training and that they realize that this orientation program is the start of the journey, they will be responsible for expanding their knowledge and applying that knowledge in the classroom.

Methodology:

Description -

The course duration shall be a minimum of 124 hours.

It is designed to consist of 24 hour of didactic presentation, in which the participants will be provided with information via lectures, small group activities, individual activities and scenarios.

Additionally, each participant must complete a 100 hour internship in which they will assist an Approved Basic EMT instructor in an actual Basic EMT class, and under supervision prepare lesson plans, teach both a lecture session and skills session and perform the administrative functions associated with an EMT course.

Coordination/Instruction

Coordination: This course shall be coordinated by, or inconjunction with, a certified Basic EMT training program.

Instruction: The instructors for the course must currently be or have been within the last 3 years, Basic EMT instructors approved by the Office of EMS and should have considerable knowledge and experience in the field of education.

Competencies:

1. List the components required in Basic Emergency Medical Technology (EMT) courses according to standards set by the United States Department of Transportation (US DOT) and the Arizona Department of Health Services Office of Emergency Medical Services (ADHS - OEMS).
2. Define and describe the concepts of adult learning as they relate to students in EMT.
3. Apply teaching principles in the design of course syllabi, and lesson plans.
4. Design a lecture outline to include identification of time, AV aides, and any student study guides.
5. Use effectively all AV and EMT equipment.
6. Design teaching methods for skills to include airway management, administrating oxygen, immobilization techniques, and application of pneumatic antishock garment (PASG).
7. Develop a student evaluation.
8. Prepare appropriate documentation for the American Heart Association (AHA), the ADHS - OEMS, and NREMT.
9. Successfully complete a multiple-choice examination on EMT-Basic knowledge and skills with 80% accuracy.
10. Successfully demonstrate application of all EMT-Basic skills according to the NREMT skills evaluation guidelines.
11. Complete 100 hours supervised classroom experience with a satisfactory evaluation.

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Course Content:

I. Orientation to US DOT, ADHS - OEMS, and NREMT Standards and Guidelines
   A. Course content
   B. Required skills

II. Principles of Adult Learning
   A. General learning theory
   B. Characteristics of learners
   C. The Domains

III. Teaching Principles
   A. Objectives for lectures and skills
   B. Syllabus and lesson plans
   C. Course calendar
   D. Student study guides

IV. Classroom Skills
   A. Components of successful lecture
   B. Components for effective teaching of skills
   C. Classroom control
   D. Discipline and counseling
   E. Discrimination
   F. Selection of text
   G. Protection of self and others

V. Audiovisual Aides
   A. Preparation and development
   B. Resources for purchase
   C. Safe use of AV equipment
   D. Safe use of monitoring and defibrillation equipment

VI. Evaluation
   A. Test Construction
      1. Multiple choice
      2. Matching
      3. Essay
      4. Completion
   B. Grading
      1. Distribution
      2. Evaluation of the course

VII. Preparation for Certification Examinations

VIII. Multiple-choice examination on EMT-Basic knowledge and skills

IX. EMT-Basic skills testing according to the NREMT skills evaluation guidelines.

X. 100 hours of supervised classroom experience which shall be the duration of 1 entire EMT class, shall be completed within 12 months, and shall include preparing lesson plans, teaching both didactic and practical skills, as well as performing all administrative functions associated with an EMT course. The participant of the instructional strategies course shall obtain a satisfactory written evaluation signed by an approved instructor and co-signed by the BLS Training Program director.

OEMS - EDUCATIONAL DEVELOPMENT
REV - January 3, 1995

Historical Note
Exhibit F adopted effective October 15, 1996 (Supp. 96-4).

R9-25-306. Preceptor Qualifications (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(1) and (3))

A. Clinical and vehicular preceptors shall be a registered nurse, physician, EMT-Basic trained under the July 22, 1994, curriculum, an intermediate with defibrillation status, or paramedic, licensed or certified by the state. At least 2 years field experience is required for all EMTs functioning as preceptors.

B. For special skills courses, vehicular preceptors shall be:
1. An intermediate with defibrillation status or paramedic, with current Arizona state certification and at least 2 years of field experience within the last 5 years.
2. A physician with 2 years of prehospital, emergency medicine, or critical care experience within the last 5 years.
3. A registered nurse who has:
   a. Either:
      i. Received instruction from the medical director in advanced airway management and has demonstrated competency in endotracheal intubation utilizing the standards of The National Registry of Emergency Medical Technicians EMT-Basic Practical Examination Users Guide, previously incorporated by reference at R9-25-304(B)(11), as verified by the medical director; or
      ii. Performs endotracheal intubation as a part of their current nursing practice;
   b. And either:
      i. 2,080 hours emergency medicine, critical care, or prehospital care clinical or teaching experience within the last 2 years; or
      ii. 200 hours experience as an instructor in a BLS Training Program with continuing vehicular preceptor experience within the last 2 years.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-307. Basic Life Support Training Program Course Requirements (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(1) and (3))

A. Department Notifications
1. The BLS Training Program shall include its certificate number on all correspondence with the Department.
2. At least 45 days prior to commencing each course, the BLS Training Program shall submit to the Department:
   a. A course approval application as shown in Exhibit C.
   b. For special skills courses, a prospective course roster listing all students to be screened for the course on the form as shown in Exhibit G.
   c. A course schedule that satisfies the minimum hourly requirements listed in subsection (C) to include: the date of each class, the module of Arizona Basic Life Support Curriculum to be covered in each class, the topic, class duration, class location, and the identity of the instructor for each lecture. The Department shall notify the BLS Training Program in writing within 30 days after it receives notice of the course schedule whether the schedule satisfies the curriculum requirements or has deficiencies. The Department shall reject a schedule that does not satisfy the requirements in subsection (C) and shall notify the BLS Training Program of the deficiencies in writing. The BLS Training Program shall submit an amended schedule within 14 days after receiving the notification. The BLS Training Program shall not commence training until it submits a course schedule that complies with subsection (C) and is approved by the Department in writing.
3. The BLS Training Program shall notify the Department of any changes in the training program director or instructor within 10 working days of the change.

B. Class Structure
1. Facility Requirements: The BLS Training Program shall ensure that each didactic session be held in a facility that provides:
   a. Restrooms within the building or campus, accessible or key available in the classroom during class hours.
   b. A minimum of 1 chair and desk or table space per student.
   c. A temperature range between 65°F. and 85°F.
   d. Lighting that evenly illuminates the room to allow the student to function within the classroom setting.
   e. An environment that is reasonably free of visual and auditory distractions.
2. Class size:
   a. Didactic: Each BLS Training Program course shall be limited to 24 students. In the lecture format, the BLS Training Program may combine 2 EMT-Basic courses for a maximum of 48 students. This combined group of 2 courses shall not exceed 20 hours of the total didactic curriculum. The training program shall not allow students enrolled in a refresher course to attend EMT-Basic courses.
   b. Skills: Skills instruction and evaluation shall be limited to a maximum ratio of 8 students to 1 instructor. The BLS Training Program shall not combine courses for skills instruction or evaluation.
3. Classroom management: The BLS Training Program shall prohibit students not enrolled in a course from attending didactic or skills instruction or evaluation.

C. Curriculum Requirements
1. Each course conducted by the BLS Training Program shall adhere to the requirements of the Arizona Basic Life Support Curriculum, dated July 22, 1994, previously incorporated by reference at R9-25-303(B)(1)(a).
2. Training for additional or subsequent protocols adopted pursuant to A.R.S. § 36-2205 shall not be implemented until the written training is adopted or amended in rule pursuant to the Arizona Administrative Procedure Act.
3. The BLS Training Program shall assure total completion of the course by offering make-up sessions for all classes required for certification that are cancelled during a course.
4. The BLS Training Program shall utilize the Basic Level Practical Examination forms contained within The National Registry of Emergency Medical Technicians EMT-Basic Practical Examination Users Guide, previously incorporated by reference at R9-25-304(B)(11).

D. Body Substance Isolation

The BLS Training Program shall comply with, and assure that its contracts with institutions and services require compliance with, the procedures described in Bloodborne Pathogens, 29 CFR § 1910.1030, amended July 1, 1995, previously incorporated by reference at R9-25-301(B)(1)(h), and §§ II and IV of The Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public-Safety Workers published by the U.S. Department of Health and Human Services, February 1989, previously incorporated by reference at R9-25-301(B)(1)(h).

E. Clinical Rotation Requirements for EMT-Basic
1. The BLS Training Program shall assure that each student receives the required hours in each clinical area described

in the Arizona Basic Life Support Curriculum, dated July 22, 1994, previously incorporated by reference at R9-25-303(B)(1)(a), for the training course in which the student is enrolled.

2. After completion of specific didactic and skills modules, all EMT-Basic students shall complete 4 sets of vital signs and the following skills during clinical rotation or supervised vehicular training, if the opportunity presents itself and under the direct supervision of a preceptor:
   a. Bag-Valve-Mask ventilation.
   b. One and 2 person cardiopulmonary resuscitation.
   c. One and 2 person pediatric resuscitation.
   d. Infant resuscitation.
   e. Adult, pediatric, and infant foreign body airway obstruction techniques.
   f. Pneumatic anti-shock garment removal under the direction and supervision of a physician.
   g. Initial patient assessment.
   h. Assist with monitoring intravenous lines.
   i. Facilitation of patient medication.
   j. Application of automatic or semiautomatic defibrillation.
3. The EMT-Basic student shall not perform patient care documentation on the hospital or institution record unless authorized by and performed under the direct supervision of the clinical preceptor.
4. The BLS Training Program shall require within their clinical site contracts that clinical preceptors be present and directly observe all student related patient care.
5. The BLS Training Program shall require that the clinical preceptors sign the student's clinical attendance and evaluation forms verifying completion of the rotation.
6. The BLS Training Program shall assure that treatments, procedures and techniques administered by the student are authorized pursuant to A.R.S. § 36-2205.

F. Examinations for EMT-Basic courses

1. The BLS Training Program may develop and shall keep on file course examinations, in addition to the final examination, given at the discretion of the training program director or medical director.
2. Prior to the completion of the course the BLS Training Program shall develop and administer final comprehensive written and practical examinations to all students. The examinations shall meet the following standards:
   a. Written Examination
      i. EMT-Basic: The final exam shall consist of 150 multiple choice questions utilizing 1 absolutely correct answer, 1 incorrect answer, and 2 distractors, neither of which is "all of the above" or "none of the above." The examination shall cover the learning objectives of the Arizona Basic Life Support Curriculum, dated July 22, 1994, previously incorporated by reference at R9-25-303(B)(1)(a), in the following proportions:

Medicolegal, Patient Handling, and Transportation	10 questions
Anatomy and Physiology and Patient Assessment	10 questions
Breathing, Resuscitation, and Cardio Pulmonary Resuscitation	25 questions
Wounds, Bleeding, Shock, Pneumatic Anti-shock Garments	10 questions
Medical Emergencies	10 questions
Injuries to the Head, Neck, Spine, Abdomen, and Genitalia	15 questions
Fractures and Dislocations	10 questions
Environmental Emergencies and Hazardous Materials	10 questions
Emergency Childbirth	10 questions
Psychological Aspects	10 questions
Medication Administration	10 questions
I.V. Monitoring	10 questions
Automatic/Semiautomatic Defibrillation	10 questions

      ii. The minimum passing grade on the final written comprehensive examination shall be no less than 75%.
      iii. The BLS Training Program may allow a student a maximum of 3 attempts to pass the final written comprehensive examination. If the student does not attain the minimum passing grade on the written comprehensive examination on the 3rd attempt, the student shall be considered ineligible to complete the program. To be eligible for certification, the ineligible student shall reapply to, be accepted by, and successfully complete an entire training program.
   b. Practical Examination
      i. The BLS Training Program shall administer a final comprehensive practical skills examination and shall utilize the Basic Level Practical Examination forms contained within The National Registry of Emergency Medical Technicians EMT-Basic Practical Examination Users Guide, previously incorporated by reference at R9-25-304(B)(11).
      ii. The minimum passing grade on the final comprehensive practical skills examination shall be 80% of possible points in each skill. Meeting any of the critical criteria listed on the testing form shall result in automatic failure of that station, regardless of the total of points accumulated.
      iii. The BLS Training Program may allow a student a maximum of 3 attempts to pass each skill of the final comprehensive practical examination. If the student does not attain the minimum passing grade on the practical examination, for each skill, on the 3rd attempt, the student shall be considered ineligible to complete the program. To be eligible for certification, the ineligible student shall reapply to, be accepted by, and successfully complete an entire training program.

G. Course Completion Requirements: The BLS Training Program may allow students who have failed to complete clinical requirements no more than 6 months from the official course completion date to complete the requirements. The BLS Training Program shall fail students who do not complete all requirements within 6 months. If the student does not complete all requirements within 6 months, the student shall be considered ineligible to complete the course. To be eligible for certification, the ineligible student shall reapply to, be

accepted by, and successfully complete an entire training program.

H. Refresher courses: The BLS Training Program may offer refresher courses that meet the requirements of the Arizona Basic EMT Refresher Curriculum, dated July 22, 1994, previously incorporated by reference at R9-25-206(I)(6)(c).

I. Special Skills Courses

1. The BLS Training Program may offer special skills courses for individuals certified as EMT-Basic in good standing. The special skills courses shall be separate from all other BLS Training Courses.
2. Student qualifications: Prospective students shall be currently certified in the state as an EMT-Basic and in good standing.
3. Special skills curriculum:
   a. The BLS Training Program shall assure that medications, treatments, procedures, and techniques administered by the student are authorized pursuant to A.R.S. § 36-2205.
   b. The BLS Training Program shall assure that each special skills course adheres to the didactic and vehicular requirements contained in the Special Skills Curriculum, dated July 22, 1994, previously incorporated by reference at R9-25-303(B)(1)(b).
   c. The BLS Training Program shall permit special skills students to begin the vehicular rotation only after all skills and didactic components of the course are successfully completed.
4. Vehicular Rotation Requirements
   a. The BLS Training Program shall assure that each student receives the required vehicular objectives and hours of vehicular training described in the Basic EMT - Special Skills Vehicular Rotation Requirements, as shown in Exhibit H.
   b. The BLS Training Program offering the EMT-Basic special skills course shall assure that a ratio of 1 preceptor to 1 student is maintained for all vehicular rotations.
   c. The BLS Training Program shall require that the preceptor be present and observe all student related patient care and co-sign the field incident report form.
   d. The BLS Training Program shall assure that medications, treatments, procedures, and techniques administered by the student are authorized pursuant to A.R.S. § 36-2205.
5. Special skills courses examinations: The BLS Training Program shall administer final written and practical examinations, that meet the following standards, to all students prior to completion of the course:
   a. Written examination:
      i. The final exam shall consist of 50 multiple choice questions utilizing 1 absolutely correct answer, 1 incorrect answer and 2 distractors neither of which is "all of the above" or "none of the above." The examination shall cover the learning objectives of the Special Skills Curriculum, dated July 22, 1994, previously incorporated by reference at R9-25-303(B)(1)(b), in the following proportions:

Medical-Legal, Patient Handling, and Transportation	10 questions
Anatomy and Physiology and Patient Assessment	10 questions
Airway, Breathing, Resuscitation, and Cardio Pulmonary Resuscitation	5 questions
Trauma	10 questions
Airway Adjuncts	5 questions
Intubation	10 questions

      ii. The minimum passing grade on the final written comprehensive exam shall be no less than 75%.
      iii. The BLS Training Program may allow a student a maximum of 3 attempts to pass the final written comprehensive examination. If the student does not attain the minimum passing grade on the written comprehensive examination on the 3rd attempt, the student shall be considered ineligible to complete the program. To be eligible for certification, the ineligible student shall reapply, be accepted by, and successfully complete the training program.
   b. Practical Examination:
      i. Following completion of the didactic component of the course, the BLS Training Program shall administer a final comprehensive practical skills examination utilizing the forms contained within The National Registry of Emergency Medical Technicians EMT-Basic Practical Examination Users Guide, previously incorporated by reference at R9-25-304(B)(11).
      ii. The minimum passing grade on the final comprehensive practical skills examination shall be 80% of possible points in each skill. Meeting any of the critical criteria listed on the testing form shall result in automatic failure of that station.
      iii. The BLS Training Program may allow a student a maximum of 3 attempts to pass each skill of the final comprehensive practical examination. If the student does not attain the minimum passing grade, for each skill, on the 3rd attempt, the student shall be considered ineligible to complete the program. To be eligible for certification, the ineligible student shall reapply, be accepted by, and successfully complete the training program.

J. Records Maintenance: The BLS Training Program shall retain all student records from all BLS courses for 2 years from the date of course commencement. These records shall include the student's name, attendance record, grades, practical skills evaluations including vehicular and clinical records, course schedules, and master copies of all examinations.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT H

Arizona Department of Health Services
Emergency Medical Services

Basic EMT - Special Skills
Vehicular Rotation Requirements

Each student must meet each objective contained on this sheet. To accomplish this a student may have to remain in the vehicular rotation for a period of time **beyond** the 8 hour minimum requirement.

Note: Preceptors must meet the minimum qualification as described in the *Arizona Administrative Code* R9-25-306(B).

Minimum Objectives

Upon completion of the vehicular rotation, with documentation supported by a skills check-off sheet (signed by the preceptor) and an EMS encounter form (which shall be signed by the student and co-signed by the preceptor), each student shall have:

1. Demonstrated the ability to perform a patient assessment on 3 patients in respiratory distress.
2. Demonstrated the ability to provide basic airway care and intervention on 3 patients.
3. Attempted a minimum of 3 endotracheal intubations in the prehospital setting.
4. Performed a minimum of 1 successful endotracheal intubation in the prehospital setting.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-308. Trainee Prerequisites (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(1) and (3))

A. Each applicant shall be at least 18 years of age prior to applying to the BLS Training Program.

B. Each applicant shall have a current Cardio Pulmonary Resuscitation card, prior to applying to the BLS Training Program.

C. Each applicant shall demonstrate proficiency in reading at the 9th grade level. Prospective students shall demonstrate reading proficiency by scoring at the 9th grade level or higher on the Nelson-Denney Examination or ABEL Examination or by attaining a minimum score of 41 on the Assessment of Skills for Successful Entry and Transfer (ASSET) Examination.

D. Each applicant shall provide proof of:
1. TB testing or chest x-ray with a negative result within 6 months prior to application.
2. Immunity to Rubella (German Measles) determined as follows:
   a. Persons born before January 1, 1942, are considered immune to Rubella (German Measles).
   b. Persons born on or after January 1, 1942, are considered immune to Rubella if:
      i. The person has a documented record of having received 1 dose of live Rubella vaccine since June 1, 1969, on or after their 1st birthday, or
      ii. The person has documented laboratory confirmation of immunity to Rubella. Physician diagnosis is not acceptable.
3. Immunity to Rubeola (Measles) determined as follows:
   a. Persons born before January 1, 1957, are considered immune to Rubeola and Mumps.
   b. Persons born on or after January 1, 1957, are considered immune to Rubeola if:
      i. The person has a documented record of having received 2 doses of live measles vaccine since January 1, 1968, on or after their 1st birthday; or
      ii. The person has documented laboratory confirmation of immunity to Rubeola. Physician diagnosis is not acceptable.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-309. Disclosure Documents (Authorized by A.R.S. § 36-2202(A)(4))

The BLS Training Program shall provide all trainee applicants with the following information in writing:
1. A description of the BLS Training Program curriculum and graduation requirements;
2. A list of books, equipment, and supplies that the student shall purchase;
3. A notification that the ability to perform certain physical activities is a mandatory requirement for both graduation and state certification and that the inability to perform these activities may disqualify the applicant from both graduation from the BLS Training Program and state certification;
4. A notification that it is the responsibility of the applicant to complete the BLS Training Program course, including final testing, within 6 months of the official course completion date in order to be eligible for graduation;
5. A copy of BLS Training Program policies and procedures that govern student conduct;
6. Notification that an EMT-Basic applicant shall successfully complete all written and practical examinations and all clinical rotations to be eligible for state certification;
7. Notification that the requirements for EMT-Basic, and special skills certification are located in the 9 A.A.C. 25, Article 5, and can be found in public libraries;
8. Notification that the Department does not regulate or insure the financial viability of the BLS Training Program;
9. Notification that for special skills courses, the student shall maintain current Arizona EMT-Basic certification throughout the special skills course or be expelled from the course;
10. Notification of required proof of immunity or immunization and negative TB test as defined in R9-25-308(D);
11. Notification that a student shall provide evidence of annual TB testing while enrolled in the program;

12. Notification that a student who contracts Tuberculosis, Rubella, Rubeola, Mumps, Varicella, or Hepatitis during the course, shall comply with the attendance policies of the course and shall not be allowed to participate in didactic, clinical, or vehicular activities until they provide written documentation from their physician that they are no longer contagious;
13. Notification of requirements that are specific to each clinical or vehicular rotation that a student must meet before beginning the rotation, which may include a physical examination or drug screening, or both.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-310. Quality Management Program (Authorized by A.R.S. §§ 36-2202(A)(4), and 36-2204(1), (3), (4), and (10))

A. Application by the BLS Training Program for certification or recertification shall constitute agreement for participation in the quality management program.

B. During the term of certification, the Department's representatives may evaluate the quality of the training program pursuant to the rules established in this Article.

C. Evaluation may consist, in whole or in part, of the following components:
1. Site visits may be conducted as follows:
   a. Each site visit may consist of the Department's representative attending a scheduled class to observe the training scheduled to occur, review the required records, interview students, and inspect equipment, supplies, and the physical location. The Department shall notify the training program director of the site visit at least 24 hours prior to the visit.
   b. During the visit, the training program director or assigned faculty shall make available to the Department's representative all requested records pertaining to the course.
   c. During the site visit the Department's representative may evaluate:
      i. Records Management - The accuracy and currency of all records and paperwork required by this Article.
      ii. Classroom Structure - The physical conditions in the classroom as required in R9-25-307(B).
      iii. Equipment and supplies as required in Exhibit D.
      iv. For each class the faculty shall be in compliance with the learning objectives of the Arizona Basic Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-303(B)(1)(a).
      v. At the conclusion of each site visit, the Department's representative may meet with the assigned faculty and verbally review the evaluation, including feedback and recommendations of the Department's representative. The Department shall prepare and provide a written report of the site visit to the training program director within 10 working days after completion of the site visit. If the written report contains a request for a corrective action plan, the report shall refer to the applicable sections of the rules for guidance.
2. The Department may conduct customer service surveys of students, faculties, preceptors, and agencies contracted with the training program to provide clinical and vehicular rotations.
   a. The surveys shall contain:
      i. The BLS Training Program's name,
      ii. The training program director's name,
      iii. The training program medical director's name, and
      iv. Questions relevant to the respondent's interaction with the training program to determine the training program's compliance with this Article.
   b. The survey question design shall elicit a "yes" or "no" response with space for comments.
   c. The Department shall maintain the results of each survey for the duration of the training programs current certificate and shall forward a copy to the BLS Training Program director.
   d. Any survey that is returned with a "no" response shall be audited by the Department in the context of other responses to determine whether a rule violation has occurred. If a violation occurred, the Department shall notify the BLS Training Program which shall develop a corrective action plan as described in this rule.

D. If corrective action is necessary, the BLS Training Program shall develop a corrective action plan within 20 working days of notification by the Department. The BLS Training Program shall submit the corrective action plan to the Department for approval. A corrective action plan shall include:
1. The specific program deficiency, including the rules violated, as determined by the Department.
2. The plan for correction of the deficiency, which shall include:
   a. A step by step procedure that the training program shall follow to correct the deficiency, and
   b. A time-line for implementation that corrects the deficiency without delay.

E. If the training program fails to develop a corrective action plan, develops a corrective action plan that does not comply with this rule, or is unable to meet the terms of the plan, the Department may initiate administrative proceedings against the training program's certificate. These proceedings may result in a letter of censure, probation, suspension, or revocation of the training program's certificate.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-311. Letter of Censure, Probation, Suspension, Revocation of Certificate (Authorized by A.R.S. § 36-2202(A)(4))

A. The director may issue a letter of censure, place on probation, suspend, or revoke a BLS Training Program certificate, in whole or in part, if any of its owners or operators, officers, agents, or employees:
1. Violate any of the rules in this Chapter.
2. Knowingly commit, aid, permit, or abet the commission of any crime involving medical or health related services.
3. Submit to the Department information required by this Article that any of its owners or operators, officers, agents, or employees knew, or should have known, was false.
4. Refuse Department personnel access to inspect facilities, equipment, or documents.

B. The Department may request an informal interview with the BLS Training Program, if it determines that an event listed in subsection (A) may have occurred.

C. The director may take the following action against the certificate if the occurrence of an event listed in subsection (A) is substantiated:

1. Issue a letter of censure or an order of probation;
2. Suspend or revoke a certificate after notice and opportunity to be heard is given according to the procedures described in A.R.S. Title 41, Chapter 6, Article 6 or 9 A.A.C. 1, Article 1.

D. The Department may suspend or revoke the certificate of a BLS Training Program during an active training course for failure to conform to this Article. In the event that the BLS Training Program's certificate is suspended or revoked during an active training course, the Department may refuse to certify graduates of that training program if it determines that the graduates did not satisfy all course requirements. If such a determination is made all students and graduates, who have not been previously certified, shall be so notified in writing by the Department.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT D

BLS EMS TRAINING PROGRAM EQUIPMENT/SUPPLIES LIST

Quantity	Equipment
1	Moulage Kits or Casualty Simulator Kits.
2	Pair of old pants and shirts.
2	Blankets (cotton or cotton/blend).
10 rolls each size	Adhesive cloth/silk type tape - ½ inch, 1 inch, 2 inch, and 3 inch.
10 rolls each size	Adhesive paper/plastic type tape - ½ inch, 1 inch, 2 inch, and 3 inch.
24	Trauma Dressings.
1 per student	Pen Lights.
1 per student	Scissors.
3	Stethoscopes.
3	Dual head training stethoscopes.
3	Blood pressure cuffs - adult sizes.
3	Blood pressure cuffs - child size.
3	Bag-valve-mask devices - adult size.
3	Bag-valve-mask devices - pediatric size.
2	Oxygen tank with regulator and key. (Must be operational and maintain a minimum of 500 psi.)
6	Oxygen masks non-rebreather - adult.
6	Oxygen masks non-rebreather - child.
6	Nasal cannulas.
2 boxes	Alcohol preps.
1 case of each size	Gloves - (small, medium, large, and extra large).
1 case	2x2 sponges.
1 case	4x4 sponges.
1 case	5x9 sponges.

2 cases	Roller gauze.
1 box	Vaseline gauze or occlusive dressings.
2	Traction splint devices.
2	Vest type immobilization devices.
2	Long spine boards with three (3) 9 foot straps per board.
3 of each size	Cervical collars (small, regular, medium, large, and extra large). **NOTE:** (Soft collars and foam types are not acceptable.)
2	Head immobilization materials/devices.
2	Pneumatic Anti-Shock Garments - adult.
2	Pneumatic Anti-Shock Garments - child.
1 set	Mobile or portable transmitter/receivers or hand held walkie talkies with fully charged batteries.
1	Ambulance stretcher.
1	Bottle of activated charcoal.
1	Oral glucose tube.
2	Portable suction device.
3	Rigid suction catheters.
3	Flexible suction catheters.
2 of each size	Oropharyngeal airways.
2 of each size	Nasopharyngeal airways.
2 of each size	Rigid splints (6 inch, 12 inch, 18 inch, 24 inch, and 36 inch.)
2	Burn sheets.
2	OB kits.
8 bottles	Sterile water.
2	CPR Mannikins - adult.
2	CPR Mannikins - child.
2	CPR Mannikins - infant.
4 per mannikin	Replacement lungs.
1 case	CPR face shields.
1	Semi-Automatic Defibrillator or AED training device.

NOTE:A box, roll, or case must be unused to be counted toward the minimum requirements. Sets and units must be complete to be counted toward the minimum requirement.

Historical Note
Exhibit D adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT C

EMERGENCY MEDICAL SERVICES

BASIC LIFE SUPPORT TRAINING PROGRAM APPLICATION
FOR CERTIFICATION / RECERTIFICATION / COURSE APPROVAL

(Mark one)

_____New Certificate

_____Recertification (certificate number) _____

_____Approval of a course to be conducted under certificate number _____

Indicate the level of the course:

_____First Responder

_____First Responder Refresher

_____Basic EMT

_____Basic EMT Refresher

_____Basic EMT Special Skills

Name of Applicant (Training Institution):	Location of Classroom:
List the names of all owners, corporate officers (attach additional sheet(s) if needed):	List all BLS training program certificates currently or previously held by the training program or its owners/corporate officers:
Mailing address:	Course Dates: Start: End: Day(s) of week: Times:
Medical Director:	Medical Director's phone number:
Program Director:	Program Director's phone number:
Course Manager:	Course Manager's phone number:

I hereby certify that the information provided in this application is correct. I verify that I have the authority to act on behalf of, and legally bind, the named agency as applicant.

Signature _____Title_____Date_____

Historical Note
Exhibit C adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT E

ARIZONA DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES

BASIC LIFE SUPPORT TRAINING PROGRAM
COURSE COMPLETION REPORT

This report shall be submitted with an Official Class Roster (form OEMS-005).

Program name _____ Certificate number _____

Program Director's name (print) _____

Medical Director's name (print) _____

Date of completion _____ Course type _____

I, as Medical Director of this training program, verify that I understand and have complied with all requirements of the Arizona Administrative Code R9-25-303.

I, as Program Director of this training program, verify that I understand and have complied with all requirements of the Arizona Administrative Code R9-25-304.

We verify that each student on the attached official class roster has:

1. *Achieved competency of every stated objective for didactic, clinical, and vehicular (for Basic EMT special skills) components of the curriculum.*
2. *Met the minimum contact hour requirements for didactic, clinical, and vehicular (for Basic EMT special skills) components as stated in the curriculum.*
3. *Demonstrated proficiency in all skills encompassed in the curriculum by successfully performing the procedure on live patients, cadavers, mannikins, or a combination of these.*

By affixing our signatures to this form we verify that each student listed on the Official Class Roster has successfully completed all requirements of the Arizona Basic Life Support Curriculum. We verify that records required by *Arizona Administrative Code*, Title 9, Chapter 25, Article 3, are available for inspection on request.

_____ _____
Medical Director Date

_____ _____
Program Director Date

Historical Note
Exhibit E adopted effective October 15, 1996 (Supp. 96-4).

ARTICLE 4. ADVANCED LIFE SUPPORT TRAINING PROGRAM CERTIFICATION EMT-INTERMEDIATE AND EMT-PARAMEDIC

R9-25-401. Advanced Life Support Training Program Certificate (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(1) and (3))

A. General Requirements
1. An ALS Training Program shall provide training only after obtaining a certificate from the Department.
2. Each certificate shall contain the name of the ALS Training Program, the name of the program medical director, the mailing address of the program's administrative office, the certificate number, and the certificate expiration date.
3. The certificate shall be conspicuously posted in the program's administrative office.
4. The program shall not transfer the certificate.
5. The certificate issued to the training program shall be the property of the Department and shall be returned to the Department immediately upon suspension or revocation.
6. A certificate is valid for a period of 2 years provided that the program complies with the conditions of this Article throughout the certification period.
7. An ALS Training Program shall not conduct training without a medical director who meets the qualifications of R9-25-403. The Department shall amend and reissue a certificate upon notification of a change of training program medical director.
8. The certificate shall name only 1 agency and 1 medical director.
9. The ALS Training Program shall maintain a current certificate for the duration of all courses and for 6 months after the course completion date for all courses to which the provisions in R9-25-407(I) apply.

B. Initial Certification Application
1. An ALS Training Program applying for initial certification shall submit the following documents to the Department at least 45 days prior to the projected commencement date of a course:
   a. An application for certification on a form provided by the Department as shown in Exhibit I, which shall be signed by an individual with authority to act

on behalf of and legally bind the named agency as applicant.

b. A copy of all agreements with institutions, and ambulance or rescue services for use of facilities, use of equipment, and for training. All agreements shall be in writing and signed by the authorized agent for the ALS Training Program and the institution or service.

c. A curriculum vitae for the training program medical director and training program director.

d. A copy of disclosure documents required by R9-25-409.

e. A list of medical equipment owned or leased by the ALS Training Program that meets the quantity specified in the ALS EMS Training Program Equipment/ Supplies List, as shown in Exhibit J.

f. An inventory of medical supplies identified in the ALS EMS Training Program Equipment/Supplies List, as shown in Exhibit J, in sufficient quantities to enable each student to successfully accomplish the lesson objectives. The ALS Training Program shall assure that each student has adequate personal protection to meet OSHA and CDC standards for Body Substance Isolation, described in Bloodborne Pathogens 29 C.F.R. § 1910.1030, amended July 1, 1995, and §§ II and IV of The Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public-Safety Workers published by the U.S. Department of Health and Human Services, February 1989, both previously incorporated by reference at R9-25-301(B)(1)(h).

g. A certificate of insurance from a company licensed to do business in the state or proof of self insurance for $500,000 malpractice and $500,000 liability protecting students, instructors, and training facilities. The ALS Training Program shall maintain this insurance or proof of self insurance during the term of its training program certificate.

h. Copies of behavioral objectives for clinical and vehicular rotations that comply with the curriculum requirements in R9-25-407(F) and (G).

2. The Department shall not accept an incomplete application and shall return the incomplete application to the applicant for completion and resubmission.

3. The ALS Training Program shall not begin training students until the certificate is issued.

C. Amendment of Certificate

1. The ALS Training Program shall notify the Department within 5 working days if its medical director resigns, is terminated, or is otherwise unable to perform the duties required under R9-25-403(B).

2. The ALS Training Program shall file a written request with the Department to have its certificate amended upon the change of the training program medical director.

3. The request shall include:

a. The name of the new medical director,

b. A copy of the new medical director's curriculum vitae.

4. The ALS Training Program shall cease training until a new medical director is appointed who meets the qualifications of R9-25-403 and receives written approval by the Department. The Department shall then issue an amended certificate.

D. Renewal of Certificate

1. An applicant for a ALS Training Program shall submit an application for recertification to the Department at least 45 days prior to the expiration of its current certificate, on a form provided by the Department as shown in Exhibit I.

2. The application shall contain the documents identified in R9-25-401(B)(1) that were amended, revised, or added since initial certification; or, a written verification that revised documents are not submitted because the information submitted with the initial application is unchanged.

3. An applicant for ALS Training Program recertification shall have conducted at least 1 intermediate, paramedic, intermediate to paramedic, or refresher course during the previous certification period.

4. An ALS Training Program which instituted a corrective action plan or is on probation may apply for renewal of its certificate. The director may issue a renewal certificate and order that the ALS Training Program complete the terms of the corrective action plan or probation as a condition of the issuance of the renewal certificate.

E. Denial of Application

1. The Department shall deny an application that does not meet the requirements for initial certification or renewal.

2. The Director may deny an initial or renewal application for an ALS Training Program certificate if any of its owners or operators have held a previous certificate and any of them or any of their officers, agents, or employees:

a. Intentionally violated any of the rules in this Article.

b. Knowingly committed, aided, permitted, or abetted the commission of any crime involving medical or health related services.

c. Submitted to the Department information required by this Article that they knew, or should have known, was false.

d. Refused Department personnel access to inspect facilities, equipment, or required documents.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-402. Operating Authority (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(1) and (3))

A. Scope: An ALS Training Program may conduct paramedic, intermediate, intermediate to paramedic, intermediate and paramedic refresher, and challenge courses.

1. The ALS Training Program shall make all notifications and maintain all documentation required by R9-25-407 or R9-25-404(B)(4) separately for each course.

2. The ALS Training Program shall not allow students to transfer between courses of different levels.

3. The ALS Training Program may allow students to attend didactic presentations in another course running concurrently as long as the total number of students attending the didactic presentation is in compliance with R9-25-407(C)(2)(a).

B. Concurrent Courses: The ALS Training Program may conduct a maximum of 3 concurrent ALS courses in any combination of the following: paramedic, intermediate, intermediate to paramedic. An ALS Training Program that wishes to conduct more than 3 concurrent courses shall request written authorization from the Department. Requests may be approved if the following conditions are met:

1. The training program is not currently operating under a corrective action plan.

2. The training program has not violated any provision of this Article within the previous 12 months.

3. Submit written statements from the program medical director, the program director, and the course manager who will be responsible for the additional course, or courses, documenting specific details and demonstrating how each has sufficient time and resources to allocate to the proposed course, or courses, in addition to their responsibilities for current courses.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-403. Medical Director (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(1) and (3))

A. The medical director of an ALS Training Program shall have the following qualifications:
1. Be licensed as a physician pursuant to A.R.S. Title 32, Chapter 13 or 17, in good standing, in the state and maintain licensure for the term of the training program certificate.
2. Be board certified by the American College of Emergency Physicians, or the American College of Osteopathic Emergency Physicians, or hold current status in advanced cardiac life support and have worked a minimum of 2,000 clinical hours in the emergency department of a licensed health care institution.

B. The medical director of an ALS Training Program shall be responsible for the following:
1. Review and approve in writing all course outlines and each lesson plan to assure they are consistent with the Arizona Advanced Life Support Curricula, dated July 22, 1994, published by and available at the Department of Health Services, Emergency Medical Services, 1651 East Morten Avenue, Suite 120, Phoenix, Arizona 85020, incorporated by reference and on file with the Department and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments. The course outlines and lesson plans shall not exceed the scope of practice established pursuant to A.R.S. § 36-2205.
2. Approve the selection of lecturers in writing to assure they meet the qualifications for each lesson they teach, as contained in the Arizona Advanced Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-403(B)(1).
3. Review performance evaluations for each student. Review performance evaluations for each lecturer who teaches over 10 hours.
4. Complete and sign the Advanced Life Support Training Program Course Completion Report as shown in Exhibit K, verifying course completion and skill competency for all students completing the course.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-404. Advanced Life Support Training Program Director (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(1) and (3))

A. The ALS Training Program director shall have the following qualifications:
1. Be currently licensed or certified for a minimum of 1 year, and in good standing, in the state as a physician, registered nurse, or paramedic and maintain licensure or certification for the term of the training program certificate.
2. Maintain current ACLS instructor status.
3. Demonstrate and maintain at least 4,160 hours of clinical experience or 180 hours of teaching experience as a physician, registered nurse, or paramedic, in prehospital care, emergency medicine, or critical care within the last 5 years.

B. The ALS Training Program director shall be responsible for the following:
1. Schedule classes and faculty, preceptors, facilities, clinical and vehicular rotations, and equipment for each class.
2. Assure that classes and clinical and vehicular rotations are conducted as scheduled and adhere to the lesson plans and objectives.
3. Assure that faculty and equipment are present at each class.
4. Establish policy and procedures for all ALS Training Program courses which, at a minimum, shall include:
   a. Attendance
      i. Absences and tardiness shall not exceed 16 hours.
      ii. The information and learning materials presented in the didactic portion of the program shall be made up under the direction of the instructor through individual instruction or documented self study projects. This shall not constitute exemption from the requirement of subsection (B)(4)(a)(i).
      iii. Clinical and vehicular absences and tardiness shall be rescheduled either prior to the official course completion date or consistent with the time limits in R9-25-307(G). A student shall arrange to make up clinical and vehicular absences or tardiness through the program director. Rescheduling of clinical and vehicular absences under this requirement shall not apply to the requirement of subsection (B)(4)(a)(i).
      iv. Students who contract a contagious disease identified in R9-25-409(13) during the course shall not participate in didactic, clinical, or vehicular activities until they provide written documentation from their physician that they are no longer contagious. If all absences, without regard to reason, exceed 16 didactic hours, the student shall not be eligible to complete the course.
   b. Grading - The program shall establish a grading policy that requires a minimum score of no less than 75% proficiency in didactic and 80% proficiency in practical skills testing.
5. Require and maintain the following records that contain the certificate number of the ALS Training Program and the names of the medical director and training program director:
   a. Attendance logs that include the class title, location, date, length of lecture, and the name of each student who attended the lecture.
   b. A gradebook for each course that includes each student's grades for all exams, projects, and evaluations. The gradebook shall indicate if a student dropped, withdrew, or was issued an incomplete.
   c. Clinical rotation logs for each student rotation that include the student's name, clinical area, and a description of skills completed by the student as observed by the preceptor. The logs shall be signed and dated by the preceptor responsible for the rotation.
   d. Vehicular logs for each student rotation that include the student's name, agency's name, unit number, field incident number, a listing of the following

advanced skills completed by the student: endotracheal intubation, establishing intravenous therapy, cricothyrotomy, thoracostomy, administration of any drug in the drug box, insertion of a gastric tube, cardiac electrical therapy, and communication with a base hospital as established by either the preceptor or student. The logs shall be signed and dated by the preceptor responsible for the rotation.

e. All examinations taken and graded in each class.

f. A course schedule that includes the location, date, time, division, section, topic, duration, and instructor for each class.

g. Skills evaluation sheets required by R9-25-407(D)(4).

h. Performance evaluations for each student completed and signed by the training program director and the student. These evaluations shall be conducted at least once during the course and shall include: the student's name, date of evaluation, attendance record, grades, areas of proficiencies and deficiencies, and a plan for improvement if deficiencies are noted.

i. Assigned written projects.

j. Instructor evaluation forms completed by students for each course faculty member teaching over 10 hours.

k. Lesson plans that cover the objectives in the Arizona Advanced Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-403(B)(1).

6. Complete the Advanced Life Support Training Program Course Completion Report as shown in Exhibit K, verifying course completion and skill competency for all students completing the course.
7. Within 10 working days after completion of each course, submit to the Department an official course roster and a course completion report on forms provided by the Department as shown in Exhibits L and R. The course roster shall contain only the names of students that complete all didactic, clinical, and vehicular requirements outlined in the Arizona Advanced Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-403(B)(1). The ALS Training Program may submit addendum rosters after the official course completion date for students who complete all requirements within 6 months after that date.
8. Assist each student in completing the paperwork necessary for the state and National Registry certification examinations.
9. Coordinate with the Department for administration of all state required testing.
10. Coordinate and schedule the National Registry Examination in compliance with The National Registry of Emergency Medical Technicians Advanced Level Examination Coordinator's Manual, published April 1992, by The National Registry of Emergency Medical Technicians, 6610 Busch Blvd., P.O. Box 29233, Columbus, Ohio 43229. The entire Coordinator's Manual is incorporated by reference and on file with the Department and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
11. Analysis of certification examination results: The ALS Training Program shall maintain a cumulative pass ratio of 70% of all students taking the certification examination.

C. The program director may assume the responsibilities of course manager or appoint a course manager to conduct the activities described in R9-25-405(B).

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-405. Course Manager (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(1) and (3))

A. The course manager of an ALS Training Program shall have the following qualifications:
1. Hold current licensure or certification in good standing in the state as a physician, pursuant to A.R.S. Title 32, Chapter 13 or 17; registered nurse, pursuant to A.R.S. Title 32, Chapter 15; or paramedic, pursuant to A.R.S. Title 36, Chapter 21.1.
2. Maintain current ACLS instructor status for all paramedic level courses; maintain current ACLS provider status for all intermediate courses.
3. Demonstrate and maintain at least 500 hours of clinical or 40 hours teaching experience in prehospital care, emergency medicine, or critical care within the last 2 years.

B. The course manager shall be responsible for the following:
1. Assure adherence to the lesson plans and objectives of the didactic portion of the course by attending at least a portion of each didactic presentation.
2. Assure adherence with the behavioral objectives of the rotations by meeting with the department head of the institution and service which provide the clinical and vehicular rotations: to,
   i. Provide and review the behavioral objectives, and preceptor qualifications, and
   ii. Responsibilities for each rotation.
3. Collect and forward documents required under R9-25-404(B)(4) to the training program director.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-406. Faculty and Preceptor Qualifications (Authorized by A.R.S. §§ 36-2202(A)(3) and (4) and 36-2204(1) and (3))

A. The ALS Training Program shall utilize faculty and preceptors currently licensed or certified in the state that meet the qualifications for the topic being taught contained in the Arizona Advanced Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-403(B)(1).

B. Clinical preceptors shall be employed by a health care institution licensed by the state or an EMS provider operating in the state.

C. Vehicular Preceptors for paramedic and intermediate to paramedic students shall be:
1. A paramedic with current Arizona state certification, in good standing, which has been valid for a minimum of 2 years as a paramedic; or
2. A physician with 4,160 hours of prehospital, emergency medicine, or critical care experience within the last 5 years; or
3. A registered nurse who has:
   a. Either:
      i. Documented proficiency in advanced airway management, central intravenous access, intraosseous access, and needle thoracostomy according to the standards for these skills contained in the Arizona Advanced Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-403(B)(1), and verified by the medical director; or

ii. Performs the skills identified in subsection (C)(3)(a)(i) as a part of their current nursing practice; and,

b. Either:

i. Demonstrate and maintain 4,160 hours emergency medicine, critical care, or prehospital care clinical or teaching experience within the last 2 years; or

ii. Demonstrate and maintain 200 hours experience as an instructor in an ALS Training Program with vehicular preceptor experience within the last 2 years.

D. Vehicular Preceptors for intermediate students shall be:

1. An intermediate or paramedic with current Arizona state certification, in good standing, which has been valid for a minimum of 2 years as an intermediate or paramedic; or
2. A physician who demonstrates and maintains 4,160 hours of prehospital, emergency medicine, or critical care experience within the last 5 years; or
3. A registered nurse who has:
   a. Either:
      i. Documented proficiency in advanced airway management, central intravenous access, intraosseous access, and needle thoracostomy according to the standards for these skills contained in the Arizona Advanced Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-403(B)(1), and verified by the medical director; or
      ii. Performs the skills identified in subsection (D)(3)(a)(i) as a part of their current nursing practice; and,
   b. Either:
      i. Demonstrate and maintain 2,080 hours emergency medicine, critical care, or prehospital care clinical or teaching experience within the last 2 years; or
      ii. Demonstrate and maintain 200 hours experience as an instructor in an ALS Training Program with vehicular preceptor experience within the last 2 years.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-407. Advanced Life Support Training Program Course Requirements (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(1) and (3))

A. Department Notifications

1. The ALS Training Program shall include its certificate number on all correspondence with the Department.
2. At least 45 days prior to commencing each course, the ALS Training Program shall submit to the Department:
   a. A course approval application as shown in Exhibit I.
   b. A prospective course roster listing all students to be screened for the course on the form as shown in Exhibit G.
   c. A course schedule that satisfies the curricula requirements listed in subsection (D) to include: the date of each class, the division and section of Arizona Advanced Life Support Curriculum to be covered in each class, the topic, class duration, class location, and the identity of the faculty for each lecture. The Department shall notify the ALS Training Program in writing within 30 days after it receives notice of the course schedule whether the schedule satisfies the curriculum requirements or has deficiencies. The Department shall reject a schedule that does not satisfy the requirements in subsection (D) and shall notify the ALS Training Program of the deficiencies in writing. The ALS Training Program shall submit an amended schedule within 14 days after receiving the notification. The ALS Training Program shall not commence training until it submits a course schedule that complies with this Section and is approved by the Department in writing.
3. The ALS Training Program shall submit to the Department the active course roster as shown in Exhibit G within 15 days of course commencement.
4. The ALS Training Program shall notify the Department of any changes in the training program director or faculty within 10 working days of the change.

B. Student Selection Requirements

1. Each ALS Training Program shall develop a written entrance examination with a minimum of 100 questions utilizing 1 absolutely correct answer, 1 incorrect answer, and 2 distractors neither of which is "all of the above" or "none of the above", that covers the following:

a.	Medicolegal, Patient Handling, and Transportation	6 questions
b.	Anatomy and Physiology and Patient Assessment	6 questions
c.	Breathing, Resuscitation, and Cardio Pulmonary Resuscitation	25 questions
d.	Wounds, Bleeding, Shock, and Pneumatic Anti-Shock Garments	14 questions
e.	Medical Emergencies	14 questions
f.	Injuries to the Head, Neck, Spine, Abdomen, and Genitalia	11 questions
g.	Fractures and Dislocations	6 questions
h.	Environmental Emergencies and Hazardous Materials	6 questions
i.	Emergency Childbirth	6 questions
j.	Psychological Aspects	6 questions

2. Each applicant shall have 1 attempt to complete the written entrance examination with a minimum score of 75% to be eligible to continue the screening process.
3. Each applicant shall have 1 attempt to demonstrate proficiency in patient trauma assessment and 1 random skill, utilizing the Basic Level Practical Examination Forms contained within The National Registry of Emergency Medical Technicians EMT-Basic Practical Examination Users Guide, previously incorporated by reference at R9-25-304(B)(11), in order to be eligible to continue the screening process.
4. The ALS Training Program shall convene an oral interview board for the purpose of selecting and ranking applicants. The oral interview board shall consist of a maximum of 5 members, which shall include:
   a. The training program medical director; and
   b. The training program director; and
   c. At least 1 licensed or certified individual who either teaches or works in prehospital care.
5. The training program oral interview process shall be designed to exclude bias.
6. The training program oral interview board shall:
   a. Develop written oral interview questions and benchmarks that assess an applicant's motivation, critical thinking, reasoning, judgment skills, and medical knowledge.
   b. Disclose to each applicant prior to beginning the interview the number of questions to be asked and that no interview shall exceed 60 minutes.

c. Prior to the oral interview process, each board member shall receive a list of applicant names. A board member shall not have a personal relationship with any applicant or receive any direct or indirect financial remuneration from any applicant on the selection list. If a board member has a personal relationship or receives any direct or indirect financial remuneration from an applicant, the board member shall not participate in the selection process for that applicant.
d. Assure that all applicants are screened with all board members present for each entire interview.
e. Assure that identical questions are read to each applicant in the same manner.

C. Class Structure
1. Facility Requirements. The ALS Training Program shall ensure that each didactic session be held in a facility that provides:
a. Restrooms within the building or campus, accessible or key available in the classroom during class hours.
b. A minimum of 1 chair and desk or table space per student.
c. A temperature range between 65°F. and 85°F.
d. Lighting that evenly illuminates the room to allow the student to function within the classroom setting.
e. An environment that is reasonably free of visual and auditory distractions.
2. Class size.
a. Didactic: Each ALS Training Program course shall be limited to 24 students. In the lecture format, the ALS Training Program may combine 2 paramedic, intermediate, or intermediate to paramedic courses for a maximum of 48 students. This combined group of 2 courses shall not exceed 60 hours of the total didactic curriculum. The training program shall not allow students enrolled in a refresher or challenge course to attend a paramedic, intermediate, or intermediate to paramedic course.
b. Skills: Skills instruction and evaluation shall be limited to a maximum ratio of 8 students to 1 instructor. The ALS Training Program shall not combine courses for skills instruction or evaluation.

D. Curriculum Requirements
1. Each course conducted by the ALS Training Program shall adhere to the requirements of the Arizona Advanced Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-403(B)(1).
2. Training for a protocol adopted pursuant to A.R.S. § 36-2205 subsequent to the effective date of this rule, shall not be implemented until the Arizona Advanced Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-403(B)(1), is amended to cover the protocol.
3. The ALS Training Program shall assure total completion of the course by offering make-up sessions for all classes required for certification that are canceled during a course.
4. For skills evaluation, the ALS Training Program shall utilize the Advanced Level and Paramedic Practical Examination forms, contained within The National Registry of Emergency Medical Technicians Advanced Level Examination Coordinator's Manual, previously incorporated by reference at R9-25-404(B)(10).

E. Body Substance Isolation. The ALS Training Program shall comply with, and assure that its contracts with institutions and services require compliance with, the procedures described in Bloodborne Pathogens, 29 CFR § 1910.1030, amended July 1, 1995, previously incorporated by reference at R9-25-301(B)(1)(h), and §§ II and IV of The Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public-Safety Workers published by the U.S. Department of Health and Human Services, February 1989, previously incorporated by reference at R9-25-301(B)(1)(h).

F. Clinical Rotation Requirements.
1. The ALS Training Program shall assure that each student receives the required hours in each clinical area described in the Arizona Advanced Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-403(B)(1), for the training course in which the student is enrolled.
2. The ALS Training Program shall require that clinical preceptors be present and directly observe all student related patient care.
3. The ALS Training Program shall require that the clinical preceptors sign the student's clinical log to verify skills and the completion of the rotation.
4. The ALS Training Program shall assure that medications, treatments, procedures, and techniques administered by the student are authorized pursuant to A.R.S. § 36-2205.
5. The ALS Training Program shall not permit an intermediate or paramedic student to begin clinical rotations until the student has successfully completed the following lessons from the Arizona Advanced Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-403(B)(1):
a. Division 2, Section 2 Assessment, 4 hours;
b. Division 2, Section 3 Airway,8 hours;
c. Division 2, Section 4 Shock, 4 hours; and
d. Division 2, Section 5 Pharmacology, 8 hours.

G. Vehicular Rotation Requirements.
1. The ALS Training Program shall assure that each student receives the required hours of vehicular training described in the Arizona Advanced Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-403(B)(1).
2. The ALS Training Program shall not permit an intermediate student to begin vehicular rotations until the student successfully completes the lesson objectives described in subsection (F)(5).
3. The ALS Training Program shall not permit a paramedic or intermediate to paramedic student to begin vehicular rotations until the student successfully completes the lesson objectives described in subsection (F)(5) and an advanced cardiac life support course.
4. The ALS Training Program shall assure that a ratio of 1 preceptor to 1 student is maintained for all vehicular rotations.
5. The ALS Training Program shall require that the preceptor be present and observe all student-related patient care and co-sign the field incident report form.
6. The ALS Training Program shall assure that medications, treatments, procedures, and techniques administered by the student are authorized pursuant to A.R.S. § 36-2205.

H. Examinations.
1. The ALS Training Program may develop and shall keep on file course examinations, in addition to the final examination, given at the discretion of the training program director or medical director.
2. Prior to the completion of the course, the ALS Training Program shall develop and administer final comprehensive written and practical examinations to all students.

3. The written examination shall consist of 150 multiple choice questions utilizing 1 absolutely correct answer, 1 incorrect answer, and 2 distractors, neither of which is "all of the above" or "none of the above," covering the learning objectives of the Arizona Advanced Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-403(B)(1), utilizing the following blueprints:

   Intermediate:

Division 1 - Prehospital	20 questions
Division 2 - Preparatory	20 questions
Division 3 - Trauma	40 questions
Division 4 - Medical	40 questions
Division 5 - Obstetrics, Gynecology, Neonatal	15 questions
Division 6 - Psychology	15 questions

   Paramedic and Intermediate to Paramedic:

Division 1 - Prehospital	20 questions
Division 2 - Preparatory	25 questions
Division 3 - Trauma	20 questions
Division 4 - Medical	40 questions
Division 4 - Cardiology	30 questions
Division 5 - Obstetrics, Gynecology, Neonatal	10 questions
Division 6 - Psychology	5 questions

4. The minimum passing grade on the final written comprehensive examination shall be no less than 75%.
5. The ALS Training Program may allow a student a maximum of 3 attempts to pass the final written comprehensive examination. If a student does not attain a minimum passing grade on the 3rd attempt, that student shall be considered ineligible to complete the program. To be eligible for certification, the student shall reapply to, be accepted by, and successfully complete an entire training program.
6. The ALS Training Program shall administer a final comprehensive practical skills examination utilizing the forms required in subsection (D)(4) following completion of the didactic, clinical, and vehicular components of the course.
7. The minimum passing grade on the final comprehensive practical skills examination shall be 80% of possible points in each skill. Meeting any of the critical criteria listed on the testing form shall result in automatic failure of that station, regardless of the total of points accumulated.
8. The ALS Training Program may allow a student a maximum of 3 attempts to pass each skill of the final comprehensive practical examination. If a student does not attain a minimum passing grade, for each skill, on the 3rd attempt that student shall be considered ineligible to complete the program. To be eligible for certification, the ineligible student shall reapply to, be accepted by, and successfully complete an entire training program.

I. The ALS Training Program shall allow students who have failed to complete clinical or vehicular requirements no more than 6 months from the official course completion date to complete the requirements. The ALS Training Program shall fail students who do not complete all requirements within 6 months. If the student does not complete all requirements within 6 months, the student shall be considered ineligible to complete the course. To be eligible for certification, the ineligible student shall reapply to, be accepted by, and successfully complete an entire training program.

J. The ALS Training Program may offer ALS Challenge Courses that shall be separate from all other ALS training courses:
1. An ALS Training Program may accept a student into a Challenge Course who holds current EMT-Basic certification in Arizona and meets 1 of the following standards:
   a. Was certified as an Arizona paramedic or intermediate, whose certification has lapsed, or
   b. Is currently certified as a paramedic in another state or is registered as a paramedic with the National Registry of Emergency Medical Technicians, or
   c. Has successfully completed an Arizona certified paramedic or intermediate training course but was not successful in completing the testing process for state certification.
2. An ALS Training Program which accepts a challenge applicant shall evaluate the applicant's current level of competency in paramedic or intermediate skills required by Arizona Advanced Life Support Refresher and Challenge Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-206(I)(6)(b).
3. Upon completion of the course, the ALS Training Program shall administer the same written and practical final examinations utilizing the same grading criteria as described in subsections (H)(4) and (7).
4. The ALS Training Program shall provide a certificate of course completion to an applicant who successfully completes course requirements and attains a minimum passing grade on the written and practical final examinations. The certificate shall be signed by the medical director and training program director verifying that the applicant meets all training requirements to apply for certification.
5. The ALS Training Program may allow a student a maximum of 3 attempts to attain a minimum passing grade on the written and practical final examinations. If the student does not attain the minimum passing grade on the final attempt, the student shall be considered ineligible to complete the program. The student shall reapply to, be accepted by and complete a new challenge course to be eligible to apply for certification.

K. The ALS Training Program may offer paramedic and intermediate refresher courses which meet the refresher course requirements in the Arizona Advanced Life Support Refresher and Challenge Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-206(I)(6)(b).

L. The ALS Training Program shall retain all student records from all ALS courses for 2 years from the date of course commencement. These records shall include the student's name, attendance record, grades, practical skills evaluations including clinical and vehicular records, course schedules, and master copies of all examinations.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-408. Trainee Prerequisites (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), and 36-2204(1) and (3))

A. Each applicant shall be certified in Arizona as an EMT-Basic or EMT-Intermediate prior to applying to the ALS Training Program.

B. Each applicant shall be employed by, or volunteer with, an agency providing patient care for emergency medical patients for a minimum of 1 year prior to the starting date of the course.

C. Each applicant shall be at least 18 years of age prior to applying to the ALS Training Program.

D. Each applicant shall provide proof of:
1. TB testing or chest x-ray with a negative result within 6 months prior to application.

2. Immunity to Rubella (German Measles) determined as follows:
   a. Persons born before January 1, 1942, are considered immune to Rubella (German Measles).
   b. Persons born on or after January 1, 1942, are considered immune to Rubella if:
      i. The person has a documented record of having received 1 dose of live Rubella vaccine since June 1, 1969, on or after their 1st birthday; or
      ii. The person has documented laboratory confirmation of immunity to Rubella. Physician diagnosis is not acceptable.
3. Immunity to Rubeola (Measles) determined as follows:
   a. Persons born before January 1, 1957, are considered immune to Rubeola and Mumps.
   b. Persons born on or after January 1, 1957, are considered immune to Rubeola if:
      i. The person has a documented record of having received 2 doses of live Measles vaccine since January 1, 1968, on or after their 1st birthday; or
      ii. The person has documented laboratory confirmation of immunity to Rubeola. Physician diagnosis is not acceptable.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-409. Disclosure Documents (Authorized by A.R.S. § 36-2202(A)(4))
The ALS Training Program shall provide all trainee applicants with the following information, in writing:
1. A description of the ALS Training Program curriculum and graduation requirements.
2. A list of books, equipment, and supplies that the applicant shall purchase.
3. A notification that the ability to perform certain physical activities is a mandatory requirement for both graduation and state certification and that the inability to perform these activities may disqualify the applicant from both graduation from the ALS Training Program and state certification.
4. A notification that it is the responsibility of the applicant to complete the ALS Training Program course, including final testing, within 6 months of the official course completion date to be eligible for graduation.
5. A copy of ALS Training Program policies and procedures that govern student conduct.
6. Notification that a paramedic, intermediate to paramedic, or intermediate applicant shall successfully complete all written and practical examinations and all clinical rotations to be eligible for state certification.
7. Notification that the requirements for paramedic and intermediate certification are located in 9 A.A.C. 25, Article 6, and can be found in public libraries.
8. Notification that the Department does not regulate or insure the financial viability of the ALS Training Program.
9. Notification that the student is required to maintain current Arizona EMT-Basic or EMT-Intermediate certification throughout the training course, or be expelled from the course.
10. Notification that a student enrolled in a paramedic course who is not able to meet the minimum requirements to graduate from the course as a paramedic shall not qualify to graduate as an intermediate.
11. Notification of required proof of immunity or immunization and negative TB test as required in R9-25-408(D).
12. Notification that a student shall provide evidence of annual TB testing while enrolled in the program.
13. Notification that a student who contracts Tuberculosis, Rubella, Rubeola, Mumps, Varicella, or Hepatitis during the course, shall comply with the attendance policies of the course, and shall not be allowed participate in didactic, clinical, or vehicular activities until they provide written documentation from their physician that they are no longer contagious.
14. Notification of requirements that are specific to each clinical or vehicular rotation that a student must meet before beginning the rotation, which may include a physical examination or drug screening, or both.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-410. Quality Management Program (Authorized by A.R.S. §§ 36-2202(A)(4), and 36-2204 (1), (3), (4), and (10))
A. Application by the ALS Training Program for certification or recertification shall constitute agreement for participation in the quality management program.
B. During the term of certification, the Department's representatives may evaluate the quality of the training program pursuant to the rules established in this Article.
C. Evaluation may consist, in whole or in part, of the following components:
1. Site visits may be conducted as follows:
   a. Each site visit may consist of the Department's representative attending a scheduled class to observe the training scheduled to occur, review the required records, interview students, and inspect equipment, supplies, and the physical location. The Department shall notify the training program director of the site visit at least 24 hours prior to the visit.
   b. During the visit, the training program director or assigned faculty shall make available to the Department's representative all requested records pertaining to the course.
   c. During the site visit the Department's representative may evaluate:
      i. Records Management - The accuracy and currency of all records and paperwork required by this Article.
      ii. Classroom Structure - The physical conditions in the classroom as required in R9-25-407(C).
      iii. Equipment and supplies as required in Exhibit J or as part of the ALS Training Program's Initial Certification application required in R9-25-401(B)(1)(f) and (g).
      iv. Faculty compliance with the learning objectives of the Arizona Advanced Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-403(B)(1), for each class.
      v. At the conclusion of each site visit, the Department's representative may meet with the assigned faculty and verbally review the evaluation, including feedback and recommendations of the Department's representative. The Department shall prepare and provide a written report of the site visit to the training program director within 10 working days after completion of the site visit. If the written report contains a request for a corrective action plan, the

report shall refer to the applicable sections of the rules for guidance.

2. The Department may conduct customer service surveys of students, faculties, preceptors, and agencies contracted with the training program to provide clinical and vehicular rotations.
   a. The surveys shall contain:
      i. The ALS Training Program's name,
      ii. The training program director's name,
      iii. The training program medical director's name, and
      iv. Questions relevant to the respondent's interaction with the training program to determine the training program's compliance with this Article.
   b. The survey question design shall elicit a "yes" or "no" response with space for comments.
   c. The Department shall maintain the results of each survey for the duration of the training program's current certificate and shall forward a copy to the ALS training program director.
   d. Any survey that is returned with a "no" response shall be audited by the Department in the context of other responses to determine whether a rule violation has occurred. If a violation occurred, the Department shall notify the ALS Training Program which shall develop a corrective action plan as described in this rule.

D. If corrective action is necessary, the ALS Training Program shall develop a corrective action plan within 20 working days of notification by the Department. The ALS Training Program shall submit the corrective action plan to the Department for approval. A corrective action plan shall include:
1. The specific program deficiency, including the rules violated, as determined by the Department.
2. The plan for correction of the deficiency, which shall include:
   a. A step by step procedure that the training program shall follow to correct the deficiency, and
   b. A time-line for implementation that corrects the deficiency without delay.

E. If the training program fails to develop a corrective action plan, develops a corrective action plan that does not comply with this rule, or the training program is unable to meet the terms of the plan, the Department may initiate administrative proceedings against the training program's certificate. These proceedings may result in a letter of censure, probation, suspension, or revocation of the training program's certificate.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-411. Letter of Censure, Probation, Suspension, Revocation of Certificate (Authorized by A.R.S. § 36-2202(A)(4))

A. The may issue a letter of censure, place on probation, suspend, or revoke an ALS Training Program certificate, in whole or in part, if any of its owners or operators, officers, agents, or employees:
1. Violate any of the rules in this Chapter.
2. Knowingly commit, aid, permit, or abet the commission of any crime involving medical or health related services.
3. Submit to the Department information required by this Article that any of its owners or operators, officers, agents, or employees knew, or should have known, was false.
4. Refuse Department personnel access to inspect facilities, equipment, or documents.

B. The Department may request an informal interview with the ALS Training Program, if it determines that an event listed in subsection (A) may have occurred.

C. The may take the following action against the certificate if the occurrence of an event listed in subsection (A) is substantiated:
1. Issue a letter of censure or an order of probation.
2. Suspend or revoke a certificate after notice and opportunity to be heard is given according to the procedures described in A.R.S. Title 41, Chapter 6, Article 6 or 9 A.A.C. 1, Article 1.

D. The Department may suspend or revoke the certificate of an ALS Training Program during an active training course for failure to conform to this Article. In the event that the ALS Training Program's certificate is suspended or revoked during an active training course, the Department may refuse to certify graduates of that training program if it determines that the graduates did not satisfy all course requirements. If such a determination is made all students and graduates, who have not been previously certified, shall be so notified in writing by the Department.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT I

EMERGENCY MEDICAL SERVICES
ADVANCED LIFE SUPPORT TRAINING PROGRAM APPLICATION
FOR CERTIFICATION / RECERTIFICATION / COURSE APPROVAL

(Mark one)

_____ New Certificate

_____ Recertification (certificate number)_____

_____ Approval of a course to be conducted under certificate number_____

Indicate the level of the course:

_____I-EMT _____Paramedic

_____I-EMT Refresher _____Paramedic Refresher

_____I-EMT Challenge _____Paramedic Challenge

_____I-EMT to Paramedic

Name of Applicant (Training Institution):	Location of Classroom:
List the names of all owners and corporate officers (attach additional sheet[s] if needed):	List all ALS training program certificates currently or previously held by the training program or its owners or corporate officers:
Mailing address:	Course Dates: Start: End: Day(s) of week: Times:
Medical Director:	Medical Director's phone number:
Program Director:	Program Director's phone number:
Course Manager:	Course Manager's phone number:

I hereby certify that the information provided in this application is correct. I verify that I have the authority to act on behalf of, and legally bind, the named agency as applicant.

Signature _____ Title _____ Date_____

Historical Note
Exhibit I adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT J

ALS EMS TRAINING PROGRAM EQUIPMENT/SUPPLIES LIST

Quantity	Equipment
1	Moulage Kits or Casualty Simulator Kits.
2	Pair of old pants and shirts.
2	Blankets (cotton or cotton/blend).
10 rolls each size	Adhesive cloth/silk type tape - ½ inch, 1 inch, 2 inch, and 3 inch.
10 rolls each size	Adhesive paper/plastic type tape - ½ inch, 1 inch, 2 inch, and 3 inch.
24	Trauma Dressings.
1 per student	Pen Lights.
1 per student	Scissors.
3	Stethoscopes.
3	Dual head training stethoscopes.
3	Blood pressure cuffs - adult sizes.
3	Blood pressure cuffs - child size.
3	Bag-valve-mask devices - adult size.
3	Bag-valve-mask devices - pediatric size.
2	Oxygen tank with regulator and key. (Must be operational and maintain a minimum of 500psi.)
6	Oxygen masks non-rebreather - adult.
6	Oxygen masks non-rebreather - child.
6	Nasal cannulas.
2 boxes	Alcohol preps.
1 case of each size	Gloves - (small, medium, large, and extra large).
1 case	2x2 sponges.
1 case	4x4 sponges.
1 case	5x9 sponges.
2 cases	Roller gauze.
1 box	Vaseline gauze or occlusive dressings.
2	Traction splint devices.

2	Vest type immobilization devices.
2	Long spine boards with three (3) 9 foot straps per board.
3 of each size	Cervical collars (small, regular, medium, large, and extra large). **NOTE:** (Soft collars and foam types are not acceptable.)
2	Head immobilization materials/devices.
2	Pneumatic Anti-Shock Garments - adult.
2	Pneumatic Anti-Shock Garments - child.
1 set	Mobile or portable transmitter/receivers or hand held walkie talkies with fully charged batteries.
1	Ambulance stretcher.
1	Bottle of activated charcoal.
1	Oral glucose tube.
2	Portable suction device.
3	Rigid suction catheters.
3	Flexible suction catheters.
2 of each size	Oropharyngeal airways.
2 of each size	Nasopharyngeal airways.
2 of each size	Rigid splints (6 inch, 12 inch, 18 inch, 24 inch, and 36 inch).
2	Burn sheets.
2	OB kits.
8 Bottles	Sterile water.
2	CPR Mannikins - adult.
2	CPR Mannikins - child.
2	CPR Mannikins - infant.
4 per mannikin	Replacement lungs.
1 case	CPR face shields.
1 box	IV Catheter - Butterfly.
1 box	IV Catheter - 24 Gauge.
1 box	IV Catheter - 22 Gauge.
1 box	IV Catheter - 20 Gauge.

1 box	IV Catheter - 18 Gauge.
1 box	IV Catheter - 16 Gauge.
1 box	IV Catheter - 14 Gauge.
1 box	IV Catheters central line catheter or intra-cath.
1 unit	Monitor/Defibrillator.
1 unit	Arrhythmia Simulator.
1 box	Electrodes.
1 unit	Arrhythmia Annie.
1 unit	Intubation Mannikin - adult.
1 unit	Intubation Mannikin - pediatrics.
1 set	Laryngoscope Handle and Blades - 1 complete set MAC or Miller.
1 set	Endotracheal Tubes - 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, and 8.5.
1	Stylet.
1 box	1 cc Syringes.
1 box	3 cc Syringes.
1 box	5 cc Syringes.
1 box	10 cc Syringes.
1 box	30 cc Syringes.
1 unit	IV Infusion Arm With Flashback.
10 Bags	IV Fluids - D5W.
10 Bags	IV Fluids - Normal Saline or lactated ringers.
10 Sets	IV Tubing - Mini.
10 Sets	IV Tubing - Standard.
10 Sets	IV Tubing - Blood.
1	Box for Sharps.
1	IV Stand.
1	Invasive Skills Mannikin - Crico, Central Lines.
1	Magill Forceps.

1	Hemostat.
3	IV Tourniquets.
3	Scalpels.
1	Simulated Drug Boxes.

NOTE: A box, roll, or case must be unused to be counted toward the minimum requirements. Sets and units must be complete to be counted toward the minimum requirement.

Historical Note
Exhibit J adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT K

ARIZONA DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES

ADVANCED LIFE SUPPORT TRAINING PROGRAM
COURSE COMPLETION REPORT

This report must be submitted with an Official Class Roster (form OEMS-005).

Program name _____ Certificate number _____

Program Director's name (print) _____

Medical Director's name (print) _____

Date of completion _____ Course type _____

I, as Medical Director of this training program, verify that I understand and have complied with all requirements of the Arizona Administrative Code R9-25-403.

I, as Program Director of this training program, verify that I understand and have complied with all requirements of the Arizona Administrative Code R9-25-404.

We verify that each student on the attached official class roster has:

1. *Achieved competency of every stated objective for didactic, clinical, and vehicular components of the Arizona Advanced Life Support Curriculum.*
2. *Met the minimum contact hour requirements for didactic, clinical, and vehicular components as stated in the Arizona Advanced Life Support Curriculum.*
3. *Demonstrated proficiency in all skills encompassed in the Arizona Advanced Life Support Curriculum by successfully performing the procedure on live patients, cadavers, mannikins or a combination of these.*

By affixing our signatures to this form we verify that each student listed on the Official Class Roster has successfully completed all requirements of the Arizona Advanced Life Support Curriculum. We verify that records required by *Arizona Administrative Code*, Title 9, Chapter 25, Article 4, are available for inspection on request.

_____ _____
Medical Director Date

_____ _____
Program Director Date

Historical Note
Exhibit K adopted effective October 15, 1996 (Supp. 96-4).

ARTICLE 5. BASIC LIFE SUPPORT CERTIFICATION

R9-25-501. Certification Application Requirements (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4), and 36-2204(1) and (6))

A. Applicant Prerequisites: An applicant for certification as an EMT-Basic shall satisfy the following requirements:
1. General Requirements. An applicant shall:
   a. Be at least 18 years of age.
   b. Submit a completed application for certification to the Department on a form as shown in Exhibit L.
   c. Verify that within the last 6 months, the applicant has not used:
      i. Illegal drugs or substances; or
      ii. Controlled drugs not prescribed for the applicant.
   d. Verify that he or she is not addicted to the use of alcohol and within the last 6 months has not consumed alcohol at work or while attending class at school.
2. EMT-Basic applicant requirements. An applicant shall provide evidence of successful completion of an EMT-Basic Training Program course certified by the Department, completed in accordance with the requirements described in R9-25-307(C).

B. Physical Requirements. Each applicant shall submit a signed statement on a form provided by the department as shown in Exhibit M verifying that he or she possesses the physical abilities and health status necessary to perform the job requirements of an EMT-Basic as listed on the form.

C. Good Character Requirements. An applicant shall certify on a form provided by the Department as shown in Exhibit N that the applicant has not been convicted of, or admitted committing, any of the following crimes:
1. Sexual abuse of a minor;
2. Driving under the influence within the last 2 years;
3. First or 2nd degree murder;
4. Kidnapping;
5. Arson;
6. Sexual assault;
7. Sexual exploitation of a minor;
8. Contributing to the delinquency of a minor;
9. Commercial sexual exploitation of a minor;
10. Felony offenses involving distribution of marijuana, or dangerous or narcotic drugs;
11. Burglary;
12. Robbery;
13. Theft;
14. A dangerous crime against children as defined in A.R.S. § 13-604.01;
15. Child or adult abuse;
16. Sexual conduct with a minor;
17. Molestation of a child;
18. Manslaughter;
19. Aggravated assault;
20. Flight to avoid prosecution; or
21. A felony or misdemeanor involving moral turpitude.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-502. Applicant Screening Process (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4) and 36-2204(1) and (6))

A. Any applicant, who has been convicted of, or admitted committing, any of the crimes listed in R9-25-501(C)(1) through (21) shall be denied certification unless the applicant has been granted an exception for good cause pursuant to the requirements of subsection (B).

B. An applicant who would otherwise be ineligible for certification because of prior criminal acts may apply to the Director in accordance with the requirements and procedures in this Section for an exception for good cause permitting certification. The applicant shall submit, or cause to be submitted, under penalty of perjury, to the Director, the following information:
1. A copy of the record of conviction, if applicable; and
2. A copy of reports relevant to the criminal offense, such as probation, presentence reports, or parole or community supervision termination reports.
3. Other evidence of the applicant's moral fitness, including letters of recommendation from law enforcement, prosecution, or correctional officers.
4. Documentation substantiating the applicant's record of employment, record of support of dependents, and record of good conduct, and whether the applicant has paid all outstanding court costs, supervision fees, fines, and restitution as may have been ordered by a court of law.
5. A signed statement providing the following:
   a. A description of the nature and seriousness of the criminal offense;
   b. The nature and extent of the applicant's conviction;
   c. The applicant's age at the time the applicant committed the criminal offense; and
   d. The amount of time that has elapsed since the applicant's last criminal offense, release from incarceration, probation, parole, community supervision, or supervised release.
6. Supporting documentation providing the following:
   a. Evidence of rehabilitative effort and lack of recidivism; and
   b. A description of the applicant's conduct and work activity before and after the criminal offense.
7. Information relating to the potential job including responsibilities, plans for supervision, and hours and days of employment.

C. The documents provided to the Director in accordance with subsection (B) shall be accompanied by the following statement signed by the applicant: "I affirm under the penalty of perjury that the information contained herein is true and correct".

D. The Director shall consider whether to allow an exception for good cause unless the individual has been convicted of, or admitted committing, any of the following offenses, or any similar offenses in any state or jurisdiction:
1. Sexual abuse of a minor;
2. First or 2nd degree murder;
3. Sexual assault;
4. Sexual exploitation of a minor;
5. Commercial sexual exploitation of a minor;
6. A dangerous crime against children as defined in A.R.S. § 13-604.01;
7. Child or adult abuse;
8. Sexual conduct with a minor;
9. Molestation of a child; or
10. Felony offenses involving distribution of marijuana, or dangerous or narcotic drugs.

E. The Director shall review the documentation and any additional relevant information and grant a good cause exception if the Director determines that there is a reasonable likelihood that the applicant:
1. Is rehabilitated and has assumed a role as a responsible, law-abiding citizen; and

2. Possesses unique or exceptional skills, education, training, or experience relating to providing EMT-Basic services; and
3. Does not present a risk to the health, welfare, or safety of patients.

F. The Director shall notify the applicant of the decision approving or denying the exception.

G. Any misrepresentation or concealment of fact by an applicant shall be grounds for denial or revocation of a good cause exception by the Director.

H. Any denial of certification or exception request pursuant to R9-25-502 shall be in the form of a written order signed by the Director or the Director's designated representative.

I. All criminal justice information received from the Department of Public Safety shall be confidential and shall not be available for public record review.

J. If an application for certification or exception is denied, the applicant may request a hearing within 15 days of the date of receipt of the notice of denial. A hearing on the denial shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 6 or 9 A.A.C. 1, Article 1.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-503. Denial of Application (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and, (4) and 36-2204(1) and (6))

The Department shall deny an application for certification as a EMT-Basic from an applicant who is on parole, probation, supervised release, or is presently incarcerated for any criminal conviction.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-504. Examinations for Initial Certification (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4) and 36-2204(1), (2), and (6))

A. Applicants shall pass written and practical examinations for EMT-Basic certification administered in accordance with the standards of The National Registry of Emergency Medical Technicians Policy and Procedures Manual, published 1992, by The National Registry of Emergency Medical Technicians, 6610 Busch Blvd., P.O. Box 29233, Columbus, Ohio 43229, incorporated by reference and on file with the Department and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments. However, when the contents of the manual are inconsistent with this Chapter, this Chapter shall take precedence. These examinations shall not be required for an applicant with a current and valid National Registry certification who is in good standing.

B. Applicants shall be given 3 opportunities to attain a passing score on all examinations, which shall be taken within 1 year after the official completion date of the training program.

C. An applicant who has failed to pass the written or any of the practical examinations after the 3rd attempt shall repeat an entire certified EMT-Basic Training Program prior to reapplication.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-505. Duration of Certification (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4) and 36-2204(1) and (6))

EMT-Basic certification shall be valid for a period of 2 years.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-506. Out-of-state Applicants (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4) and 36-2204(1), (2), and (6))

A. An applicant who holds current and valid certification as an EMT-Basic in good standing issued by another state or jurisdiction shall be certified in Arizona after meeting the following requirements:
1. Compliance with all requirements described in R9-25-501 and R9-25-502.
2. Submission of a completed application on a form provided by the Department as set forth in Exhibit L.
3. Submission of evidence of a current and valid certification issued by the National Registry of Emergency Medical Technicians, or a state, or a political subdivision.
4. After December 31, 1998, submission of written verification from a certified training program or ALS base hospital of having successfully completed training that meets the requirements of the Arizona BLS Curriculum in the following:
   a. Semi-automatic defibrillator,
   b. Patient-assisted medications,
   c. Blood glucose monitoring,
   d. Patient assessment,
   e. SIDS (Sudden Infant Death Syndrome), and
   f. IV monitoring.

B. If an out-of-state applicant does not hold a current and valid certification issued by the National Registry of Emergency Medical Technicians, the applicant shall apply for and successfully complete the written and practical examinations for EMT-Basic certification administered or approved by the Department in accordance with the requirements of the National Registry of Emergency Medical Technicians.

C. Certification issued to an applicant meeting the requirements under this Section shall be valid for 2 years.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-507. Applicants With Disabilities (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4) and 36-2204(1), (2), and (6))

A. Special examination accommodations may be made for individuals with diagnosed learning disabilities in the areas of reading decoding or reading comprehension, or some form of documented disability or cognitive processing deficit which would negatively affect an applicant's performance on the written examination.

B. No special accommodations shall be made for the practical examination.

C. Applicants requesting special accommodations for the written examination shall submit the request to the medical director at least 30 days prior to the date of the written examination together with evidence that documents the diagnosis of a learning disability in the area of reading decoding or reading comprehension based upon the results of a standardized psychoeducational assessment including a standardized measure of intelligence and a standardized measure of achievement in reading decoding or reading comprehension.

D. The medical director shall grant accommodations for 150% of the normally allotted time to complete the written examination to applicants who have obtained testing accommodations from the National Registry of Emergency Medical Technicians and have complied with this rule.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-508. Scope of Practice (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4), and 36-2204(1), (6), and (8), and 36-2205)

A. Individuals certified as an EMT-Basic shall be authorized to provide medical treatments, procedures, medications, and techniques:
1. As outlined in the Arizona Basic Life Support Curriculum, dated July 22, 1994, previously incorporated by reference at R9-25-303(B)(1)(a); or
2. Having first completed an approved protocol training module, may perform those skills, permitted by protocol pursuant to A.R.S. § 36-2205.

B. Individuals certified as an EMT-Basic shall be authorized to provide medical treatments, procedures, medications, and techniques described in subsection (A) only under the administrative medical control of a BLS medical director or ALS Base Hospital.

C. A certified EMT-Basic shall be authorized to monitor peripheral intravenous lines after having successfully completed IV monitoring training, by a certified BLS Training Program or ALS Base Hospital, that meets the requirements described in the Arizona Basic Life Support Curriculum, dated July 22, 1994, previously incorporated by reference at R9-25-303(B)(1)(a).

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4). Subsection (A)(2) corrected to reflect adopted rules on file with the Office of the Secretary of State, effective October 15, 1996 (Supp. 97-1).

R9-25-509. Special Skills Certification (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4) and 36-2204(1))

A. A certified EMT-Basic shall be authorized to perform endotracheal intubation skills upon meeting the following qualifications:
1. Be employed by an EMS provider which is providing such services and has a written and signed provider agreement with an ALS Base Hospital to provide medical direction and continuing education.
2. Possess a certificate of training issued by a certified BLS Training Program or certified ALS Base Hospital documenting successful completion of endotracheal intubation training as shown in the Special Skills Curriculum, dated July 22, 1994, previously incorporated by reference at R9-25-303(B)(1)(b).
3. Successfully complete a written examination administered or approved by the Department with a score of 75% or greater within 1 year of the completion date of the advanced airway training. The EMT-Basic shall have 3 opportunities to attain a passing score. An EMT-Basic who has failed to pass the written examination after the 3rd attempt shall repeat an advanced airway training course.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-510. Recertification Requirements for EMT-Basic (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4), and 36-2204(1), (4), and (6))

A. An applicant for EMT-Basic recertification shall have been in compliance with all requirements of this Article during the current certification period and shall submit to the Department:
1. A completed application on a form provided by the Department, as shown in Exhibit O.
2. Evidence of reregistration with the National Registry of Emergency Medical Technicians or, evidence of successful completion of an EMT-Basic refresher training course that meets the requirements described in the Arizona Basic EMT Refresher Curriculum, dated July 22, 1994, previously incorporated by reference at R9-25-206(I)(6)(c), conducted by a certified BLS Training Program or ALS Base Hospital.
3. A signed statement on a form provided by the Department, as shown in Exhibit M, verifying that he or she possesses the physical abilities and health status necessary to perform the job requirements of an EMT-Basic as listed on the form.
4. A written form accompanying the application for recertification from the BLS medical director responsible for the applicant's administrative medical control for the current certification period, as shown in Exhibit P.

B. An applicant for recertification shall submit evidence of successful completion of the requirements listed in subsection (A) not less than 30 days prior to the expiration of the applicant's current certificate.

C. An applicant who applies for recertification shall not function as an EMT-Basic, after expiration of the current certification, until recertified by the Department.

D. Each EMT-Basic shall pass an examination administered or approved by the Department every 4 years as a condition for recertification. An applicant for recertification shall attain a passing grade of 75% on the examination. An applicant shall have 3 attempts to attain a passing grade on the examination. An applicant who fails the examination on all 3 attempts shall complete an entire EMT-Basic Training Program prior to reapplying.

E. All applicants applying for recertification after December 31, 1998, shall have successfully completed training that meets the requirements described in the Arizona Basic EMT Refresher Curriculum, dated July 22, 1994, previously incorporated by reference at R9-25-206(I)(6)(c), to include, at a minimum, the following:
1. Semi-automatic defibrillator,
2. Patient-assisted medications,
3. Blood glucose monitoring,
4. Patient assessment,
5. SIDS (Sudden Infant Death Syndrome), and
6. IV monitoring.

F. An applicant who has not applied for recertification by the expiration date of his or her certificate, and applies within the 2 year period following that expiration date, may regain certification by successfully completing the examinations required in R9-25-504, after meeting the requirements set forth in subsections (A)(1) through (4).

G. An applicant whose certificate has been expired for over 2 years shall meet all of the requirements for initial certification as set forth in these rules.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT P

Arizona Department of Health Services
Emergency Medical Services

RECOMMENDATION FOR BLS RECERTIFICATION

_____ _____
Applicant's Name Social Security Number

_____ _____
Certification Number Expiration Date

_____
Applicant's Address

This is to verify that the applicant identified above has been under my administrative medical direction for a minimum of 6 months, has no performance related patient care issues that are unresolved, and is recommended for recertification pursuant to *Arizona Administrative Code* R9-25-510.

_____
BLS Medical Director's Signature AZ License # Date

_____
Applicant's Signature Date

Historical Note
Exhibit P adopted effective October 15, 1996 (Supp. 96-4).

R9-25-511. Recertification for EMT-Basic Special Skills (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4) and 36-2204(1), (4), and (6))

A. The EMT-Basic certified to perform endotracheal intubation shall submit to the Department:
1. A completed application on a form provided by the Department, as shown in Exhibit O.
2. Evidence of reregistration with the National Registry of Emergency Medical Technicians, or evidence of successful completion of a Basic EMT refresher training course that meets the requirements described in the Arizona Basic EMT Refresher Curriculum, dated July 22, 1994, previously incorporated by reference at R9-25-206(I)(6)(c), conducted by a certified BLS Training Program.
3. Evidence of successful completion of an endotracheal intubation skills workshop during the certification period covering the objectives as shown in the Special Skills Curriculum, dated July 22, 1994, previously incorporated by reference at R9-25-303(B)(1)(b).
4. A letter recommending the applicant for recertification, signed by the ALS Base Hospital medical director and ALS Base Hospital program manager who have been responsible for administrative medical direction of the EMT-Basic during the previous 90 days.

B. An applicant for recertification shall submit evidence of successful completion of the requirements listed in subsection (A) not less than 30 days prior to the expiration of the applicant's current certificate.

C. An applicant who applies for recertification for EMT-Basic Special Skills shall not function as an EMT-Basic Special Skills, after expiration of the current certification, until recertified by the Department.

D. Each EMT-Basic shall pass an examination administered or approved by the Department every 4 years as a condition for recertification. An applicant for recertification shall attain a passing grade of 75% on the examination. An applicant shall have 3 attempts to attain a passing grade on the examination. An applicant who fails the examination on all 3 attempts shall complete an entire EMT-Basic Training Program prior to reapplying.

E. All applicants applying for recertification after December 31, 1998, shall have successfully completed training that meets the requirements described in the Arizona Basic EMT Refresher Curriculum, dated July 22, 1994, previously incorporated by reference at R9-25-206(I)(6)(c), to include, at a minimum, the following:
1. Semi-automatic defibrillator,
2. Patient-assisted medications,
3. Blood glucose monitoring,
4. Patient assessment,
5. SIDS (Sudden Infant Death Syndrome), and
6. IV monitoring.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4). Subsection (C) corrected to reflect adopted rules on file with the Office of the Secretary of State, effective October 15, 1996 (Supp. 97-3).

R9-25-512. Extension of Recertification Application Requirements (Authorized by A.R.S. §§ 36-2202 (A)(2), (3), and (4) and 36-2204(1), (2), and (3))

A. An EMT-Basic who has not met the requirements of R9-25-510(A) prior to the expiration of his or her current certificate may apply for 1 extension to file for recertification. The request for extension shall be made to the Director prior to the expiration date of the current certification.

B. The applicant for extension shall not practice as an EMT-Basic after the expiration date of the current certification.

C. An application for an extension shall be submitted to the Department, on an extension form provided by the Department as shown in Exhibit Q, which contains the following:

1. Applicant's name, address, and phone number;
2. EMS employers name, address, and phone number;
3. Applicant's certification number and date of expiration;
4. Statement signed by the applicant, under penalty of perjury, that the applicant was unable to complete the recertification requirements during the effective period of the certification and verified by an attached, signed statement as follows:
   a. Physician licensed in Arizona who provides evidence of a mental or physical disability or health problem that has precluded the applicant from meeting the recertification requirements;
   b. Applicant's superior officer who documents that the applicant has been involved in military duty that has precluded the applicant from meeting the recertification requirements; or
   c. Third party who supports an undue hardship claim that has precluded the applicant from meeting the recertification requirements.

D. The request for extension shall be granted for a term no greater than 180 days.

E. An applicant who does not meet recertification requirements prior to the expiration of their certification shall complete an entire EMT-Basic Training Program and meet requirements of R9-25-501.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Subsection A corrected to reflect adopted rules on file with the Office of the Secretary of State, effective October 15, 1996 (Supp. 97-1). Subsection A corrected again to reflect adopted rules on file with the Office of the Secretary of State, effective October 15, 1996 (Supp. 97-3).

R9-25-513. Inactive Status Due to Temporary Medical Condition (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4), and 36-2204(6))

A. An applicant who is unable to meet the requirements of recertification due to a temporary medical condition may apply to be placed on an inactive status by the Director for a period of 24 months from the expiration date of the applicant's certification.

B. An applicant shall submit to the Director:

1. Written verification from a physician describing the applicant's temporary medical condition, the date of onset, a statement estimating the length of time that the condition will be present, a description of the applicant's physical limitations, and a statement that the applicant is unable to perform the job duties of an EMT-Basic; and
2. A written request to place the applicant's certification on inactive status pending resolution of the medical condition.

C. The Director shall inform the applicant in writing whether the application was granted based on input from the medical director as to the applicant's temporary medical condition. The applicant shall not perform the job duties of an EMT-Basic during the term of inactive status.

D. Prior to the expiration of the inactive status, the applicant may apply for recertification, and shall submit documents required in R9-25-510(A).

E. The applicant shall pass a written examination if required by A.R.S. § 36-2202(D).

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-514. Reporting Requirements (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4), and 36-2204(1) and (6))

An EMT-Basic affiliated with an agency shall ensure that:

1. A first care form documenting all patient care provided by the EMT-Basic is completed for each patient encounter.
2. The form is signed by each EMT-Basic providing care.
3. The original or a legible copy of this report is provided to the prehospital provider, or the nurse or physician at the receiving facility accepting transfer of patient care, and the person providing the EMT-Basic's administrative medical direction.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-515. Enforcement Actions (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4) and 36-2204(1), (6), and (7))

A. Under A.R.S. § 36-2211, the following factors shall be considered unprofessional conduct:

1. Conduct as an EMT in another jurisdiction which resulted in denial, suspension, or revocation of the EMT's certificate or license.
2. Intentionally or negligently causing physical injury to a patient under the EMT's care or treatment.
3. Abandoning or neglecting a patient requiring emergency medical care without making arrangements to continue such care as the patient required.
4. Performing treatment above the level of the EMT's current level of certification.
5. Use of, or being under the influence of any, narcotic, dangerous drug, or an intoxicating beverage to the extent that the use or influence impairs the judgment of the EMT while providing service as an EMT or ambulance attendant.
6. Obtaining, possessing, administering, or using any narcotic or controlled substance in violation of federal or state law.
7. Willful destruction of, falsification of, or making a materially inaccurate statement on a record of patient treatment or care.
8. Impersonation of an EMT of higher level of certification.
9. Conviction of or admission to committing any of the crimes listed in R9-25-501(C).

B. Under A.R.S. § 36-2211 mental or physical incompetence shall be considered a lack of mental or physical ability to perform the duties or any duty of an EMT.

C. Under A.R.S. § 36-2211 gross incompetence or gross negligence shall be considered a willful act or omission in disregard of an individual's life, health, or safety which may cause death or injury.

D. Under A.R.S. § 36-2211 willful fraud or misrepresentation shall be considered a false statement or action taken by an individual with the intent to directly or indirectly benefit himself or herself or mislead another.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

ARTICLE 6. ADVANCED LIFE SUPPORT CERTIFICATION

R9-25-601. Certification Application Requirements (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4), and 36-2204(1) and (6))

A. Applicant Prerequisites: An applicant for certification as a paramedic or intermediate shall satisfy the following requirements:
1. General Requirements. An applicant shall:
   a. Be at least 18 years of age;
   b. Submit a completed application for certification to the Department on a form as shown in Exhibit L;
   c. Verify that within the last 6 months, the applicant has not used:
      i. Illegal drugs or substances, or
      ii. Controlled drugs not prescribed for the applicant.
   d. Verify that he or she is not addicted to the use of alcohol and within the last 6 months has not consumed alcohol at work or while attending class at school.
   e. Be currently certified as an EMT-Basic or EMT-Intermediate in the state.
2. Paramedic applicant requirements. An applicant shall provide evidence of completion of a paramedic or intermediate to paramedic training program course certified by the Department or a challenge course completed in accordance with the requirements prescribed in R9-25-407.
3. Intermediate applicant requirements. An applicant shall provide evidence of successful completion of an intermediate training program course certified by the Department or a challenge course completed in accordance with the requirements prescribed in R9-25-407.

B. Physical Requirements. Each applicant shall submit a signed statement on a form provided by the department as shown in Exhibit M verifying that he or she possesses the physical abilities and health status necessary to perform the job requirements of an EMT-Intermediate or EMT-Paramedic as listed on the form.

C. Good Character Requirements. An applicant shall certify on a form provided by the Department as shown in Exhibit N that the applicant has not been convicted of, or admitted committing, any of the following crimes:
1. Sexual abuse of a minor;
2. Driving under the influence within the last 2 years;
3. First or 2nd degree murder;
4. Kidnapping;
5. Arson;
6. Sexual assault;
7. Sexual exploitation of a minor;
8. Contributing to the delinquency of a minor;
9. Commercial sexual exploitation of a minor;
10. Felony offenses involving distribution of marijuana, or dangerous or narcotic drugs;
11. Burglary;
12. Robbery;
13. Theft;
14. A dangerous crime against children as defined in A.R.S. § 13-604.01;
15. Child or adult abuse;
16. Sexual conduct with a minor;
17. Molestation of a child;
18. Manslaughter;
19. Aggravated assault;
20. Flight to avoid prosecution; or
21. A felony or misdemeanor involving moral turpitude.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-602. Applicant Screening Process (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4) and 36-2204(1) and (6))

A. Any applicant who has been convicted of, or admitted committing, any of the crimes as listed in R9-25-601(C) shall be denied certification unless the applicant has been granted an exception for good cause pursuant to the requirements of subsection (B).

B. An applicant who would otherwise be ineligible for certification because of prior criminal acts may apply to the Director in accordance with the requirements and procedures in this Section for an exception for good cause permitting certification. The applicant shall submit, or cause to be submitted, under penalty of perjury, to the Director, the following information:
1. A copy of the record of conviction, if applicable;
2. A copy of reports relevant to the criminal offense, such as probation, presentence reports, or parole or community supervision termination reports;
3. Other evidence of the applicant's moral fitness, including letters of recommendation from law enforcement, prosecution, or correctional officers;
4. Documentation substantiating the applicant's record of employment, record of support of dependents, and record of good conduct, and whether the applicant has paid all outstanding court costs, supervision fees, fines, and restitution as may have been ordered by a court of law.
5. A signed statement providing the following:
   a. A description of the nature and seriousness of the criminal offense;
   b. The nature and extent of the applicant's conviction;
   c. The applicant's age at the time the applicant committed the criminal offense; and
   d. The amount of time that has elapsed since the applicant's last criminal offense, release from incarceration, probation, parole, or community supervision.
6. Supporting documentation providing the following:
   a. Evidence of rehabilitative effort and lack of recidivism; and
   b. A description of the applicant's conduct and work activity before and after the criminal offense.
7. Information relating to the potential job including responsibilities, plans for supervision, and hours and days of employment.

C. The documents provided to the Director in accordance with subsection (B) shall be accompanied by the following statement signed by the applicant: "I affirm under the penalty of perjury that the information contained herein is true and correct".

D. The Director shall consider whether to allow an exception for good cause unless the individual has been convicted of, or admitted committing, on any of the following offenses or any similar offenses in any state or jurisdiction:
1. Sexual abuse of a minor;
2. First or 2nd degree murder;
3. Sexual assault;
4. Sexual exploitation of a minor;
5. Commercial sexual exploitation of a minor;
6. A dangerous crime against children as defined in A.R.S. § 13-604.01;
7. Child or adult abuse;

8. Sexual conduct with a minor;
9. Molestation of a child; or
10. Felony offenses involving distribution of marijuana, or dangerous or narcotic drugs.

E. The Director shall review the documentation and any additional relevant information and grant a good cause exception if the Director determines that there is a reasonable likelihood that the applicant:
1. Is rehabilitated and has assumed a role as a responsible, law-abiding citizen; and
2. Possesses unique or exceptional skills, education, training, or experience relating to providing EMT services; and
3. Does not present a risk to the health, welfare, or safety of patients.

F. The Director shall notify the applicant of the decision approving or denying the exception.

G. Any misrepresentation or concealment of fact by an applicant shall be grounds for denial or revocation of a good cause exception by the Director.

H. Any denial of certification or exception request pursuant to R9-25-602, shall be in the form of a written order signed by the Director or the Director's designated representative.

I. All criminal justice information received from the Department of Public Safety shall be confidential and shall not be available for public record review.

J. If an application for certification or exception is denied, the applicant may request a hearing within 15 days of the date of receipt of the notice of denial. A hearing on the denial shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 6 or 9 A.A.C. 1, Article 1.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-603. Denial of Application (Authorized by A.R.S. §§ 36- 2202(A)(2), (3), and (4) and 36-2204(1) and (6))
The Department shall deny an application for certification as an EMT-Intermediate or EMT-Paramedic from an applicant who is on parole, probation, supervised release, or is presently incarcerated for any criminal conviction.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-604. Examinations for Initial Certification (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4) and 36-2204(1), (2), and (6))

A. Applicants shall pass written and practical examinations for paramedic or intermediate certification administered or approved by the Department in accordance with the National Registry of Emergency Medical Technicians Advanced Level Examination Coordinator's Manual, previously incorporated by reference at R9-25-404(B)(10). However, when the contents of this manual are inconsistent with this Chapter, this Chapter shall take precedence. These examinations shall not be required for an applicant with a current and valid National Registry certification as a paramedic or intermediate in good standing.

B. Applicants shall be given 3 opportunities to attain passing scores on all examinations, which shall be taken within 1 year after the official completion date of the training program.

C. An applicant who has failed to pass the written or practical examination after the 3rd attempt shall repeat a certified paramedic or intermediate training program or challenge course prior to reapplication.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-605. Duration of Certification (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4) and 36-2204(1) and (6))
Paramedic or intermediate certification shall be valid for a period of 2 years.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-606. Out-of-state Applicants (Authorized by A.R.S. §§ 36-2202(A)(2), (3) and (4) and 36-2204(1), (2), and (6))

A. An applicant who holds current and valid certification as a paramedic in good standing issued by another state or jurisdiction shall be certified in Arizona after meeting the following requirements:
1. Compliance with all requirements described in R9-25-601, R9-25-602, and R9-25-604(B);
2. Submission of a completed application on a form provided by the Department as set forth in Exhibit L;
3. Submission of evidence of a current and valid certification issued by the National Registry of Emergency Medical Technicians, or a state, or a political subdivision;
4. Submission of evidence of successful completion of a challenge course as described in R9-25-407(J).

B. If an out-of-state applicant does not hold a current and valid certification issued by the National Registry of Emergency Medical Technicians, the applicant shall apply for and successfully complete the written and practical examinations for EMT-Paramedic certification administered or approved by the Department in accordance with the requirements of the National Registry of Emergency Medical Technicians.

C. Certification issued to an applicant meeting the requirements under this Section shall be valid for 2 years.

D. An out-of-state applicant who is certified as an intermediate in another state or jurisdiction shall complete an intermediate training program in the state of Arizona prior to applying for certification.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-607. Applicants With Disabilities (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4), and 36-2204(1), (2), and (6))

A. Special examination accommodations may be made for individuals with diagnosed learning disabilities in the areas of reading decoding or reading comprehension, or some form of documented disability or cognitive processing deficit which would negatively affect an applicant's performance on the written examination.

B. No special accommodations shall be made for the practical examination.

C. Applicants requesting special accommodations for the written examination shall submit the request to the medical director at least 30 days prior to the date of the written examination together with evidence that documents the diagnosis of a learning disability in the area of reading decoding or reading comprehension based upon the results of a standardized psychoeducational assessment including a standardized measure of intelligence and a standardized measure of achievement in reading decoding or reading comprehension.

D. The medical director shall grant accommodations for 150% of the normally allotted time to complete the written examination to applicants who have obtained testing accommodations from the National Registry of Emergency Medical Technicians and have complied with this Section.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-608. Scope of Practice (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and(4), and 36-2204(1), (6), and (8), and 36-2205))

A. Individuals certified as a paramedic or intermediate shall be authorized to provide medical treatments, procedures, medications, and techniques:
1. As outlined in the Arizona Advanced Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-403(B)(1); or
2. Having 1st completed an approved protocol training module, may perform those skills, permitted by protocol, pursuant to A.R.S. § 36-2205.

B. Individuals certified as a paramedic or intermediate shall be authorized to provide medical treatments, procedures, medications, and techniques described in subsection (A) only under the direction of an ALS Base Hospital certified pursuant to 9 A.A.C. 25, Article 2.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-609. Extended Scope of Practice Training Requirements (Authorized by A.R.S. §§ 36-2202(A) (2), (3), and (4), and 36-2204(1))

Immunization Training Requirements. A paramedic or intermediate may administer immunizations according to the protocol established in R9-13-1501 upon successful completion of the following requirements:

1. Curriculum Requirements: Each immunization trainee shall complete all of the objectives of the ALS Prehospital Provider Immunization Training Curriculum, dated July 11, 1994, published by and available at the Department of Health Services, Emergency Medical Services, 1651 E. Morten Avenue, Suite 120, Phoenix, Arizona 85020, incorporated by reference and on file with the Department and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments. The curriculum shall be approved by a medical director who is:
   a. A physician licensed in the state and:
      i. Is currently practicing in General Medicine, Family Practice, Internal Medicine, Pediatrics, or Emergency Medicine;
      ii. Is accessible by phone, beeper, or in person during all phases of training;
      iii. Signs the course completion certificate for each trainee who successfully completes the ALS Prehospital Provider Immunization Training Curriculum; and
      iv. Provides to paramedics or intermediates trained to administer immunizations, immunization schedule changes and updates on immunobiologics as they become available.
2. The curriculum shall be taught by the medical director or an instructor with the following qualifications:
   a. Licensed registered nurse in the state with either a:
      i. Bachelor of Science Degree, or
      ii. 2 years experience administering immunizations in a pediatric or public health setting, or
   b. Physician or physician's assistant licensed in the state currently practicing in General Practice, Family Practice, Internal Medicine, Pediatrics, or Emergency Medicine.
3. Competency Requirements: Each immunization trainee shall demonstrate competency by obtaining a score of 80% or better on each of the following examinations:
   a. The final written examination which shall consist of 100 multiple choice questions utilizing 1 absolutely correct answer, 1 incorrect answer, and 2 distractors, neither of which is "all of the above" or "none of the above," covering the learning objectives of the ALS Prehospital Provider Immunization Training Curriculum, dated July 11, 1994, previously incorporated by reference at R9-25-609(1), in the following proportions:

i.	Epidemiology	15 questions
ii.	Immunization Scheduling	15 questions
iii.	Vaccine Screening	10 questions
iv.	Vaccine Administration	20 questions
v.	Adverse Reactions	10 questions
vi.	Vaccine Management	15 questions
vii.	Liability	5 questions
viii.	Documentation	5 questions
ix.	OSHA Requirements	5 questions

   b. The final practical examination which shall assess each skill outlined on the check off sheets as shown in Exhibit R.
   c. The trainee shall have a maximum of 3 attempts to pass the final written examination and the final practical examination. If the trainee does not attain the passing grade on either of the examinations by the 3rd attempt, the trainee shall complete another immunization training program prior to being retested.
4. Course Completion Certificate Requirements: The instructor and medical director who approved the training curriculum shall sign and issue a course completion certificate to a trainee who completes the course and passes the final examinations. The course completion certificate shall be valid for 1 year from the date on which the trainee successfully completes the final examinations.
   a. Prior to administrating immunizations, ALS personnel shall provide a copy of the course completion certificate to the medical director of an Immunization Clinic evidencing successful completion of immunization administration training as required by R9-13-1501.
   b. ALS personnel shall be responsible to keep and safeguard the course completion certificate.
5. Continuing Education and Renewal of Course Completion Certificate Requirements:
   a. The ALS personnel shall complete yearly continuing education in immunization administration.
   b. The continuing education shall cover the following topics from the ALS Prehospital Provider Immunization Training Curriculum:
      i. Routine immunization scheduling;
      ii. Vaccine screening process;
      iii. Vaccine administration;
      iv. Management of adverse reactions;
      v. Vaccine management; and
      vi. Documentation.
   c. The continuing education course shall utilize a medical director and instructor who meet the qualifications and satisfy the responsibilities identified in subsections (1) and (2).
      i. Upon completion of the continuing education course, the ALS personnel shall have 3 attempts to attain a passing score of 80% on the final written examination identified in subection (3)(a) prior to receiving a course completion certificate. If the ALS personnel does not

attain the passing grade on the final written examination by the 3rd attempt, the ALS personnel shall complete another continuing education course prior to being retested.

ii. The medical director and instructor shall sign and issue a new course completion certificate to the ALS personnel who completes the continuing education course and passes the final examination. The course completion certificate shall be valid for 1 year from the date on which the ALS personnel successfully completes the examination.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT R

Immunization Training
Practical Evaluation Form

Station #1
Record Assessment, Screening, and Consent

Student Name: _____ Evaluator:_____

Date:_____

Competency	Satisfactory	Unsatisfactory
Given an immunization record/history, determines the required vaccinations.		
Verifies client's identity as being that of person named on the immunization record.		
Verifies signature and relationship of consenting adult.		
Documents any vaccines deferred or refused.		
Appropriately answers questions regarding "Important Information"		
Screens for contraindications and possible risks.		
When presented with a "delayed" child, determines appropriate immunizations and scheduling.		
Thoroughly completes necessary consent forms and instructs parent appropriately.		

Immunization Training
Practical Evaluation Form

Station #_____(2, 3, and 4)
Immunobiologics Administration

Student Name: _____ Evaluator: _____

Date: _____

Competency	Satisfactory	Unsatisfactory
Verifies client's identity as being that of person named on the immunization records.		
Proofs consent form, making sure biologics to be administered are accurate.		
Confirms child or infant is in the proper holding position prior to administering the medication.		
Demonstrates proper biologic administration in each of the following sites and routes: A/L Thigh_____ IM _____ Deltoid _____ SQ_____ Post. Arm _____ IM _____		
Chooses appropriate needle gauge and length to administer biologic.		
Prepares appropriate dosage for a given biologic. (Write example of medication evaluated) Biologic_____ Dose _____		
Demonstrates proper injection techniques when giving biologics.		
Disposes of needles/syringes in sharps container properly and according to OSHA regulations.		
Provides appropriate post immunization administration education to the client or consenting adult.		
Completes documentation immediately following vaccine administration.		
Uses universal infection control precautions when indicated.		

Immunization Training
Clinical Evaluation Form

Clinical site location: _____

Student Name: _____ Evaluator:_____

Date: _____

Competency	Satisfactory	Unsatisfactory
Sets up clinic supplies, to include emergency drugs and standing protocols.		
Dress is appropriate with identification clearly visible.		
Given a specific age, identifies appropriate biologic(s).		
Verifies client identity as being that of person named.		
Verifies signature and relationship of consenting adult.		
Verifies holding position of child or infant prior to administration of medication and administers the medication without undue harm to self or client.		
Demonstrates proper vaccination administration in each of the following sites and routes: A/L Thigh_____ IM_____ Deltoid_____ SQ_____ Post. Arm_____ IM_____		
Documents any deferred or refused biologics.		
Disposes of needles/syringes in sharps container properly and according to OSHA regulations.		
Provides appropriate post immunization administration education to the client or consenting adult.		
Completes documentation immediately following biologic administration.		
Uses universal infection control precautions when indicated.		

Comments:

_____

_____

Student's Signature _____

Historical Note

Exhibit R adopted effective October 15, 1996 (Supp. 96-4).

R9-25-610. Paramedic Recertification Requirements (Authorized by ARS §§ 36-2202(A)(2), (3), and (4), and 36-2204(1), (4), and (6))

A. An applicant for paramedic recertification shall have been in compliance with all requirements of this Article, during the current certification period.

a. ACLS and BCLS provider course completion: a maximum of 24 hours.

B. An applicant for paramedic recertification shall complete 60 hours of continuing medical education in the following categories:

1. Category I (Mandatory). One hour of continuing education credit shall be given for 1 hour of instruction received.

b. Prehospital case reviews: minimum of 12 hours.
c. Base hospital lectures: minimum of 12 hours.
d. Skills Workshops: Training in endotracheal intubation, needle thoracostomy, surgical cricothyrotomy, intraosseous infusion, and central venous lines that meets the requirements and objectives described in the Arizona Advanced Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-403(B)(1). A minimum of 4 hours and a maximum of 20 hours.

2. Category II (Electives)
a. An EMT-Paramedic refresher training program which meets the requirements and objectives of the Arizona Advanced Life Support Refresher and Challenge Curricula, dated July 22, 1994, previously incorporated by reference at R9-206(I)(6)(b). A maximum of 48 hours.
b. EMS health related college courses provided by an educational institution which is accredited by the New England Association of Schools and Colleges, Middle States Association of Colleges and Secondary Schools, North Central Association of Colleges and Schools, Northwest Association of Schools and Colleges, Southern Association of Colleges and Schools, or the Western Association of Schools and Colleges: 3 hours of continuing education hours per credit unit of courses to a maximum of 12 continuing education hours.
c. Conference, Didactic, or Lecture sessions on subjects which meet 1 or more of the objectives as established in R9-25-407(K). Maximum of 30 hours.
d. Clinical experience supervised by a preceptor who meets the qualification in R9-25-406. Maximum of 20 hours.
e. Teaching: maximum of 20 hours of instruction in a certified EMT program, or Basic Cardiac Life Support, Advanced Cardiac Life Support, Prehospital Trauma Life Support, or Basic Trauma Life Support. Credit shall not be given for the same course taught more than once during the period of certification.
f. Vehicular preceptor for a certified training program: maximum of 20 hours.
g. EMS related multimedia instruction: maximum of 20 hours.

C. The applicant shall submit to the Department the following documents at least 30 days prior to the expiration of the current certification period:
1. An application on a form provided by the Department as shown in Exhibit O.
2. A written statement verifying that the applicant has met all the requirements for recertification on a form as shown in Exhibit S.
3. A signed statement on a form provided by the Department as shown in Exhibit M, verifying that he or she possesses the physical abilities and health status necessary to perform the job requirements of an EMT-Paramedic as listed on the form.

D. Paramedics shall pass an examination administered or approved by the Department with a 75% or greater as a condition for recertification if required to do so by their base hospital medical director. Each applicant shall have 3 attempts to pass the examination. Applicants who fail the examination on all 3 attempts shall complete an entire EMT-Paramedic Training Program or challenge course prior to reapplying.

E. An applicant who has not applied for recertification by the expiration date of his or her certificate, and applies within the 2 year period following that expiration date, may regain certification by successfully completing a paramedic refresher course as described in the Arizona Advanced Life Support Refresher and Challenge Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-206(I)(6)(b), or a Paramedic Challenge course as described in R9-25-407(J), and successfully completing the examinations required in R9-25-604.

F. An applicant whose certificate has been expired for over 2 years shall meet all of the requirements for initial certification.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-611. Intermediate Recertification Requirements (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4), and 36-2204(1), (4), and (6))

A. An applicant for intermediate recertification shall have been in compliance with all requirements of this Article during the current certification period.

B. An applicant for intermediate recertification shall complete 50 hours of continuing medical education in the following categories:
1. Category I (Mandatory). An applicant for intermediate recertification shall complete the following:
a. BCLS provider course completion: a maximum 8 hours.
b. Twelve hours of prehospital case reviews.
c. Twelve hours of base hospital lectures.
d. Skills workshops: Training in endotracheal intubation, needle thoracostomy, surgical cricothyrotomy, and intraosseous infusion that meets the requirements and objectives described in the Arizona Advanced Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-403(B)(1). A minimum of 4 hours and a maximum of 20 hours.
2. Category II (Electives) An applicant for intermediate recertification shall complete 20 hours of continuing education in any combination of the following:
a. An EMT-Intermediate Refresher Training Program which meets the refresher course requirements in the Arizona Advanced Life Support Refresher and Challenge Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-206(I)(6)(b). A maximum of 48 hours.
b. Prehospital case reviews in excess of those required in category I.
c. Base hospital lectures in excess of those required in category I.
d. A maximum of 4 hours of skills workshops in excess of those required in category I: Training in endotracheal intubation, needle thoracostomy, surgical cricothyrotomy, and intraosseous infusion that meets the requirements and objectives described in the Arizona Advanced Life Support Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-403(B)(1).
e. EMS health related college courses provided by an educational institution which is accredited by the New England Association of Schools and Colleges, Middle States Association of Colleges and Secondary Schools, North Central Association of Colleges and Schools, Northwest Association of Schools and Colleges, Southern Association of Colleges and Schools, or the Western Association of Schools and Colleges: 3 hours of continuing education hours per

credit unit of courses to a maximum of 12 continuing education hours.
f. Paramedic training course hours.
g. Conference, Didactic, or Lecture sessions on subjects which meet 1 or more of the objectives as established in R9-25-206(I)(6)(b). Maximum of 30 hours.
h. Clinical experience supervised by a preceptor who meets the qualifications in R9-25-406. Maximum of 20 hours.
i. Teaching, a maximum of 20 hours of instruction in a certified EMT program, or Basic Cardiac Life Support, Prehospital Trauma Life Support, or Basic Trauma Life Support. Credit shall not be given for the same course taught more than once during the period of certification.
j. Vehicular preceptor for a certified training program: maximum of 20 hours.
k. EMS related multimedia instruction: maximum of 20 hours.

C. The applicant shall submit to the Department the following documents at least 30 days prior to the expiration of the current certification period:
1. An application on a form provided by the Department as shown in Exhibit O.
2. A written statement verifying that the applicant has met all the requirements for recertification on a form as shown in Exhibit S.
3. A signed statement on a form provided by the Department as shown in Exhibit M, verifying that he or she possesses the physical abilities and health status necessary to perform the job requirements of an EMT-Intermediate as listed on the form.

D. An applicant shall pass an examination administered or approved by the Department with a 75% or greater as a condition for recertification if required to do so by his or her base hospital medical director. Each applicant shall have 3 attempts to pass the examination. Applicants who fail the examination on all 3 attempts shall complete an entire EMT-Intermediate Training Program or challenge course prior to reapplying.

E. An applicant who has not applied for recertification by the expiration date of his or her certificate, and applies within the 2 year period following that expiration date, may regain certification by successfully completing an EMT-Intermediate refresher course which meets the refresher course requirements in the Arizona Advanced Life Support Refresher and Challenge Curricula, dated July 22, 1994, previously incorporated by reference at R9-25-206-(I)(6)(b), or an EMT-Intermediate challenge course as described in R9-25-407(J), and successfully completing the examinations required in R9-25-604.

F. An applicant whose certificate has been expired for over 2 years shall meet all of the requirements for initial certification.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-612. Extension of Recertification Application Requirements (Authorized by A.R.S. §§ 36- 2202(A)(2), (3), and (4), and 36-2204(1), (4), and (6))

A. An applicant who has not met the requirements in R9-25-610(B) and (C), or R9-25-611(B) and (C) prior to the expiration of his or her current certificate, may apply for 1 extension to file for recertification. The request for extension shall be made to the Director prior to the expiration date of the current certification.

B. The applicant for extension shall not practice as a paramedic or an intermediate after the expiration date of the current certification.

C. An application for an extension shall be submitted to the Department on an extension form provided by the Department as shown in Exhibit Q, which contains the following:
1. Applicant's name, address, and phone number;
2. EMS employer's name, address, and phone number;
3. Applicant's certification number and date of expiration;
4. Statement signed by the applicant, under penalty of perjury, that the applicant was unable to complete the recertification requirements during the effective period of the certification and verified by an attached signed statement as follows:
   a. Physician licensed in Arizona who provides evidence of a mental or physical disability or health problem that has precluded the applicant from meeting the recertification requirements;
   b. Applicant's superior officer who documents that the applicant has been involved in military duty that has precluded the applicant from meeting the recertification requirements; or
   c. Third party who supports an undue hardship claim that has precluded the applicant from meeting the recertification requirements.

D. The request for extension may be granted for a term no greater than 180 days.

E. An applicant who does not meet recertification requirements prior to the expiration of their extension, shall complete an entire EMT-Intermediate or paramedic training program and meet the requirements of R9-25-601.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-613. Inactive Status Due to Temporary Medical Condition (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4) and 36-2204(6))

A. An applicant who is unable to meet the requirements of recertification due to a temporary medical condition may apply to be placed on an inactive status by the Director for a period of 24 months from the expiration date of the applicant's certification.

B. An applicant shall submit to the Director:
1. Written verification from a physician describing the applicant's temporary medical condition, the date of onset, a statement estimating the length of time that the condition will be present, a description of the applicant's physical limitations, and a statement that the applicant is unable to perform the job duties of an EMT-Intermediate or EMT-Paramedic; and
2. A written request to place the applicant's certification on inactive status pending resolution of the medical condition.

C. The Director shall inform the applicant in writing whether the application was granted based on input from the medical director as to the applicant's temporary medical condition. The applicant shall not perform the job duties of an EMT-Intermediate or EMT-Paramedic during the term of inactive status.

D. Prior to the expiration of the inactive status, the applicant may apply for recertification and shall submit:
1. Documents required in R9-25-610(C).
2. Evidence of successful completion of an intermediate or paramedic refresher course as described in the Arizona Advanced Life Support Refresher and Challenge Curricula, dated July 22, 1994, previously incorporated by ref-

erence at R9-25-206(I)(6)(b), or the continuing education requirements of R9-25-610 or R9-25-611.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-614. Downgrading of Certification (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4), and 36-2204(1) and (6))

A. A paramedic or intermediate who has current certification and who is in good standing may voluntarily elect to downgrade their level of certification for the remainder of their certification period. The applicant shall:
1. Meet all requirements in R9-25-601(A)(1) or R9-25-501(A)(1); and
2. Submit a written recommendation from the base hospital medical director verifying their ability to perform at the lower level of certification; and
3. Successfully complete the examination for recertification required for the lower level.

B. A certified paramedic or intermediate in good standing may voluntarily elect to recertify at a lower level of certification. The applicant shall meet all requirements in R9-25-510 or R9-25-611.

C. An application for downgrading of certification or recertification, at a lower level, shall not be approved if the applicant is under investigation pursuant to A.R.S. § 36-2211 or 9 A.A.C. 25, Article 5 or 6.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-615. Reporting Requirements (Authorized by A.R.S. §§ 36-2202(A)(2), (3), and (4), and 36-2204(1) and (6))

A paramedic or intermediate affiliated with an agency shall ensure that:
1. A first care form documenting all patient care provided by the paramedic or intermediate is completed for each patient encounter.
2. The form is signed by each paramedic or intermediate providing care.
3. The original or a legible copy of this report is provided to the prehospital provider, or the nurse or physician at the receiving facility accepting transfer of patient care, and the person providing the paramedic or intermediate administrative medical direction.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

R9-25-616. Enforcement Actions (Authorized by A.R.S. §§ 36- 2202(A)(2), (3), and (4), and 36-2204(1), (6), and (7))

A. Under A.R.S. § 36-2211, the following factors shall be considered unprofessional conduct:
1. Conduct as an EMT in another jurisdiction which resulted in denial, suspension, or revocation of the EMT's certificate or license.
2. Intentionally or negligently causing physical injury to a patient under the EMT's care or treatment.
3. Abandoning or neglecting a patient requiring emergency medical care without making arrangements to continue such care as the patient required.
4. Performing treatment above the level of the EMT's current level of certification.
5. Use of, or being under the influence of, any narcotic, dangerous drug, or intoxicating beverage to the extent that the use or influence impairs the judgement of the EMT while providing service as an EMT or ambulance attendant.
6. Obtaining, possessing, administering, or using any narcotic or controlled substance in violation of federal or state law.
7. Willful destruction of, falsification of, or making a materially inaccurate statement on a record of patient treatment or care.
8. Impersonation of an EMT of higher level of certification.
9. Performing an advanced procedure without medical direction.
10. Conviction of or admission to committing any of the crimes listed in R9-25-601(C).

B. Under A.R.S. § 36-2211, mental or physical incompetence shall be considered a lack of mental or physical ability to perform any duty of an EMT.

C. Under A.R.S. § 36-2211, gross incompetence or gross negligence shall be considered a willful act or omission in disregard of an individual's life, health, or safety which may cause death or injury.

D. Under A.R.S. § 36-2211, willful fraud or misrepresentation shall be considered a false statement or action taken by an individual with the intent to directly or indirectly benefit himself or herself or mislead another.

Historical Note
Adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT S

Arizona Department of Health Services
Emergency Medical Services

VERIFICATION OF ALS RECERTIFICATION REQUIREMENTS

Applicant's Name _____ Social Security Number _____

Certification Number _____ Expiration Date _____

Applicant's Address _____

This is to verify that the applicant identified above has completed all continuing education requirements according to *Arizona Administrative Code* R9-25-611.

Documentation of all continuing education credit hours will be made available to the Department upon request.

Base Hospital Coordinator's Signature _____ Date _____

Base Hospital Medical Director's Signature _____ Date _____

Applicant's Signature _____ Date _____

Historical Note
Exhibit S adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT G

ARIZONA DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES

CLASS ROSTER

(Check one) _____Prospective _____Active _____Official _____Addendum

TOTAL NUMBER OF STUDENTS ON ROSTER:_____

PROGRAM CERTIFICATION OR ID NUMBER: _____

TYPE OF COURSE:_____ LOCATION OF COURSE:_____

DATE OF COURSE: _____ _____
START DATE END DATE

TOTAL HOURS:_____ DIDACTIC:_____ CLINICAL:_____ VEHICULAR:_____

PROGRAM DIRECTOR:_____ COURSE MANAGER:_____

MEDICAL DIRECTOR:_____

NAME	HOME ADDRESS	SOCIAL SECURITY #
	EMPLOYER	CERT # & EXP DATE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

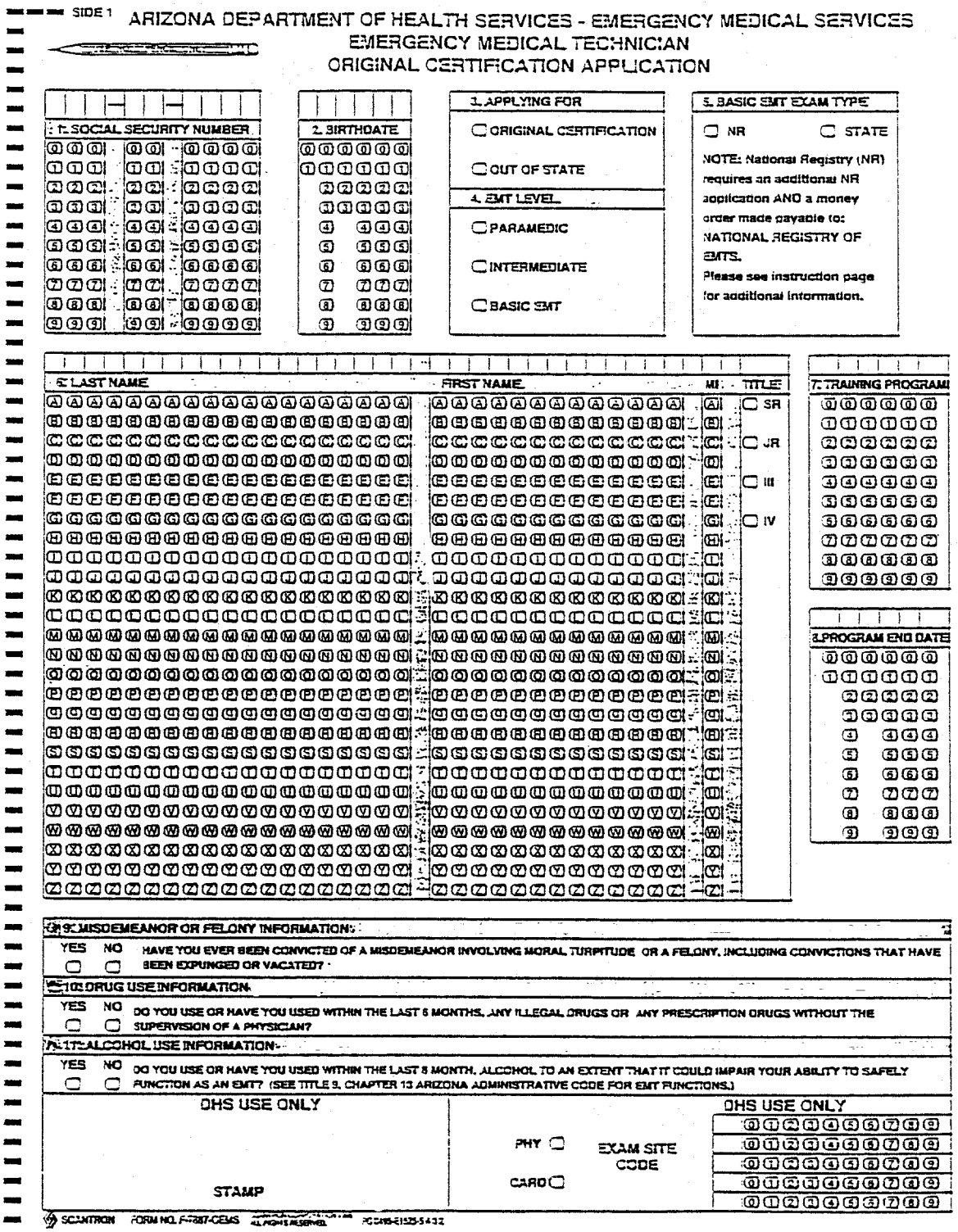
USE OTHER SIDE FOR ADDITIONAL NAMES PAGE 1 OF 2

ADHS OEMS-005

NAME	HOME ADDRESS	SOCIAL SECURITY #
	EMPLOYER	CERT # & EXP DATE
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		

Historical Note
Exhibit G adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT L


SIDE 1

ARIZONA DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES
EMERGENCY MEDICAL TECHNICIAN
ORIGINAL CERTIFICATION APPLICATION

1. SOCIAL SECURITY NUMBER

2. BIRTHDATE

3. APPLYING FOR
- ORIGINAL CERTIFICATION
- OUT OF STATE

4. EMT LEVEL
- PARAMEDIC
- INTERMEDIATE
- BASIC EMT

5. BASIC EMT EXAM TYPE
- NR
- STATE

NOTE: National Registry (NR) requires an additional NR application AND a money order made payable to: NATIONAL REGISTRY OF EMTS.
Please see instruction page for additional information.

6. LAST NAME | FIRST NAME | MI | TITLE
- SR
- JR
- III
- IV

7. TRAINING PROGRAM

8. PROGRAM END DATE

9. MISDEMEANOR OR FELONY INFORMATION:
YES NO HAVE YOU EVER BEEN CONVICTED OF A MISDEMEANOR INVOLVING MORAL TURPITUDE OR A FELONY, INCLUDING CONVICTIONS THAT HAVE BEEN EXPUNGED OR VACATED?

10. DRUG USE INFORMATION:
YES NO DO YOU USE OR HAVE YOU USED WITHIN THE LAST 6 MONTHS, ANY ILLEGAL DRUGS OR ANY PRESCRIPTION DRUGS WITHOUT THE SUPERVISION OF A PHYSICIAN?

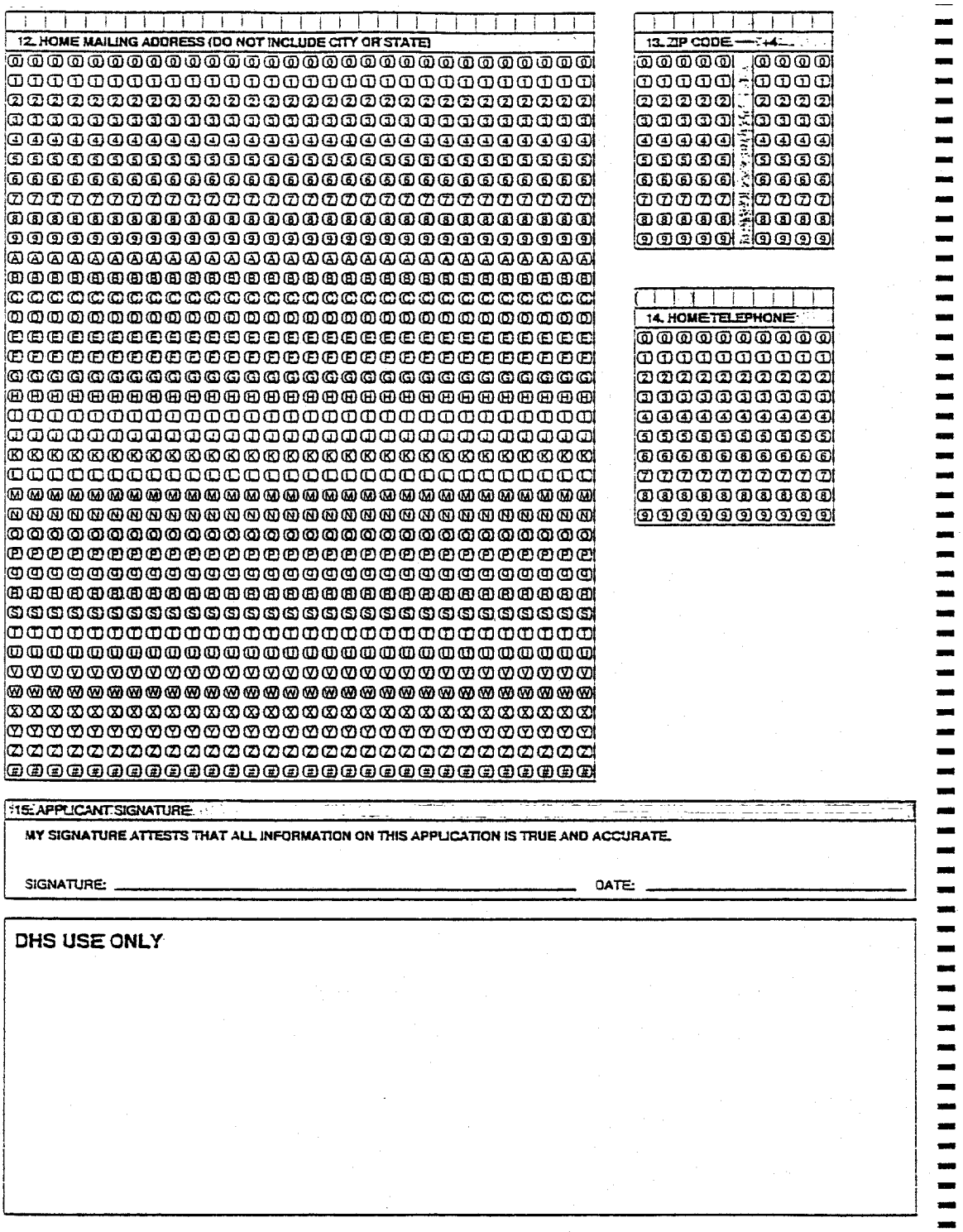
11. ALCOHOL USE INFORMATION:
YES NO DO YOU USE OR HAVE YOU USED WITHIN THE LAST 6 MONTH, ALCOHOL TO AN EXTENT THAT IT COULD IMPAIR YOUR ABILITY TO SAFELY FUNCTION AS AN EMT? (SEE TITLE 9, CHAPTER 13 ARIZONA ADMINISTRATIVE CODE FOR EMT FUNCTIONS.)

DHS USE ONLY
STAMP

PHY
CARD
EXAM SITE CODE

DHS USE ONLY

SCANTRON FORM NO. F-7887-CEMS ALL RIGHTS RESERVED PO 0495-61525-5432



Historical Note
Exhibit L adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT M

Arizona Department of Health Services
Emergency Medical Services

PHYSICAL VERIFICATION FORM

This document is a medical record and shall be kept confidential subject to *Arizona Administrative Code* R9-1-312.

To be completed by the applicant.

Applicant's Name: (PRINT) _____

Social Security or OEMS Certification ID # _____

CAUTION: Persons providing false information may be subject to prosecution for a class 5 felony under A.R.S.§ 13-2311. Persons who gain certification based on false information may, under A.R.S. § 36-2211, be subject to suspension or revocation, and civil penalties up to $2,500.00.

PLEASE READ: An applicant must be capable of performing a wide range of functions that require vision, hearing, speech, and physical capabilities. Each applicant should be free from any medical or psychological diseases or disorders that would impact the applicant's ability to perform the duties of an EMT or which may put the applicant or patients at risk.

If you have a medical or psychological disease or disorder that would prevent you from performing the duties of an EMT, a specific review of your case shall be conducted and the State Medical Director, ADHS-EMS, will make a determination. If you require a review of your case, please contact the Certification Manager, ADHS-EMS, prior to completing an application.

FUNCTIONS OF AN EMT:

The following paragraph details typical functions performed by an EMT:

Ability to communicate verbally via telephone and radio equipment; ability to lift, carry, and balance 125 pounds independently and 250 pounds with assistance; ability to interpret written, oral, and diagnostic form instructions; ability to use good judgement and remain calm in high stress situations; ability to be unaffected by loud noises and flashing lights; ability to function efficiently throughout an entire work shift, at times up to 24 hours, without interruption; ability to read small print, such as on medication vials; ability to accurately discern street signs and address numbers in the sunlight and at night; ability to converse in English with co-workers and hospital staff as to the status of patients; good manual dexterity, with ability to perform all tasks related to the highest quality patient care; ability to bend, stoop, and crawl on uneven terrain; ability to withstand varied environmental conditions such as extreme heat, cold, and moisture; ability to work in low light and confined spaces.

Is there any reason why you would not be able to perform the functions of an EMT as described above? (If you responded "yes", please contact ADHS-EMS).	Yes	No

Under penalty of perjury, I verify that the information contained on this form is true and accurate.

Applicant's Signature: _____ Date: _____

Historical Note
Exhibit M adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT N

EMERGENCY MEDICAL SERVICES CRIMINAL HISTORY DISCLOSURE FOR EMERGENCY MEDICAL TECHNICIAN CERTIFICATION APPLICATION

CAUTION: PERSONS PROVIDING FALSE INFORMATION MAY BE SUBJECT TO PROSECUTION FOR A CLASS 5 FELONY UNDER A.R.S. § 13-2311. PERSONS WHO GAIN CERTIFICATION BASED ON FALSE INFORMATION MAY, UNDER A.R.S. § 36-2211, BE SUBJECT TO SUSPENSION OR REVOCATION, AND CIVIL PENALTIES UP TO $2,500.00.

Print your name: _____

Check the correct response (YES) (NO) to each of the following questions:

1) Are you presently on parole, probation, supervised release, or incarcerated for any criminal conviction? _____(YES) _____(NO)
2) Are you awaiting trial on any of the following criminal offenses in this state, or similar offenses in another state or jurisdiction? _____(YES) _____(NO)
3) Have you ever been convicted of any of the following criminal offenses in this state, or similar offenses in another state or jurisdiction? _____(YES) _____(NO)
4) Have you ever admitted in open court to committing any of the following criminal offenses in this state, or similar offenses in another state or jurisdiction? _____(YES) _____(NO)
5) Have you ever admitted pursuant to a plea agreement committing any of the following criminal offenses in this state, or similar offenses in another state or jurisdiction? _____(YES) _____(NO)

A. Sexual abuse of a minor.

B. Driving under the influence within the last two years.

C. First or Second degree murder.

D. Kidnapping.

E. Arson.

F. Sexual assault.

G. Sexual exploitation of a minor.

H. Contributing to the delinquency of a minor.

I. Commercial sexual exploitation of a minor.

J. Felony offenses involving distribution of marijuana or dangerous or narcotic drugs.

K. Burglary.

L. Robbery.

M. Theft.

N. A dangerous crime against children as defined in A.R.S. § 13-604.01 (see below)

O. Child or adult abuse.

P. Sexual conduct with a minor.

Q. Molestation of a child.

R. Manslaughter.

S. Aggravated assault.

T. Flight to avoid prosecution.

Under penalty of perjury, I verify that the information contained on this form is true and accurate.

_____ _____

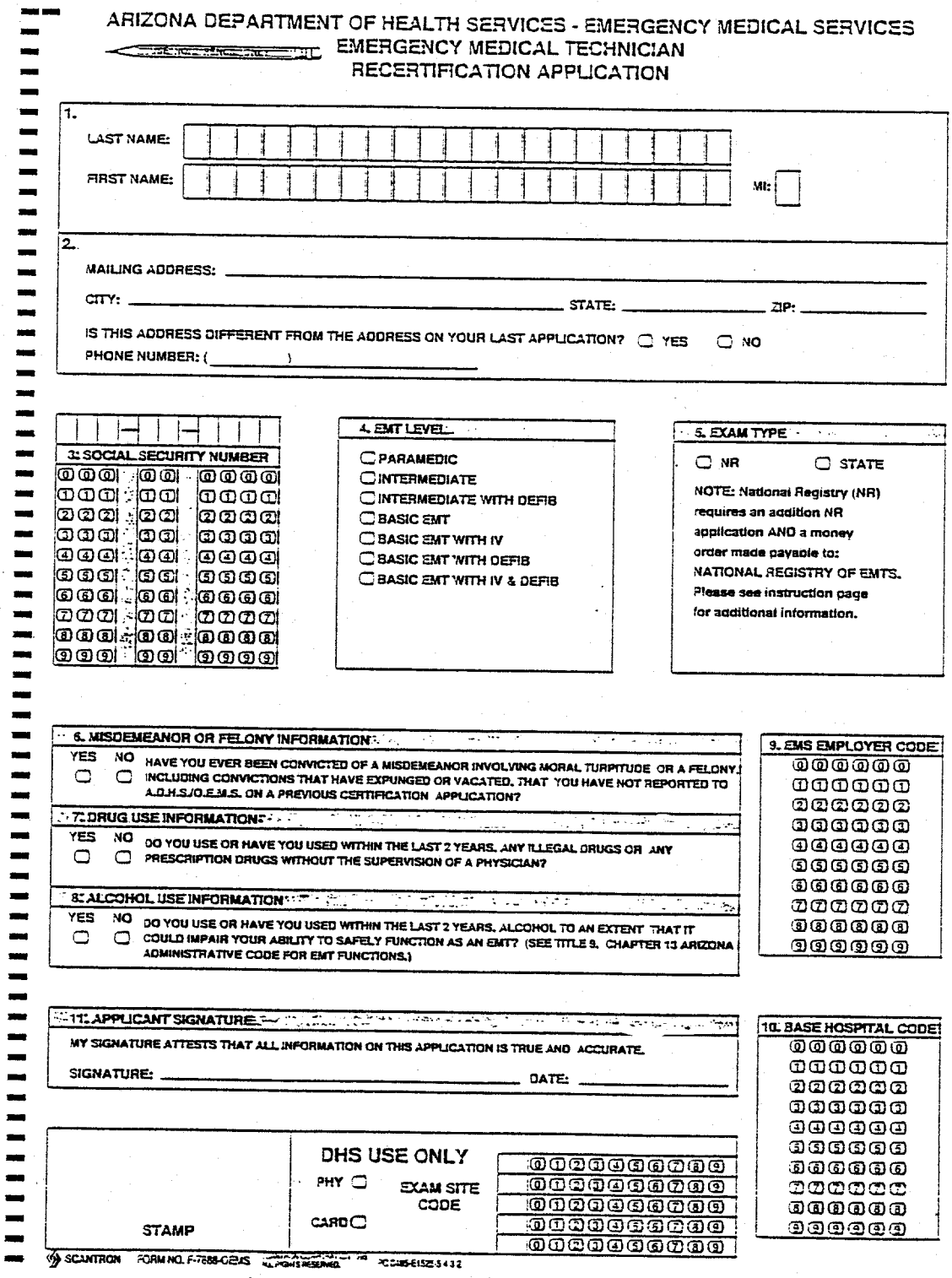
Signature of applicant Date

A.R.S. § 13-604.01(J)(1) states: "Dangerous crime against children" means any of the following committed against a minor under fifteen years of age: (a) Second degree murder. (b) Aggravated assault resulting in serious physical injury or involving the discharge, use or threatening exhibition of a deadly weapon or dangerous instrument. (c) Sexual assault. (d) Molestation of a child. (e) Sexual conduct with a minor. (f) Commercial sexual exploitation of a minor. (g) Sexual exploitation of a minor. (h) Child abuse as defined in §13-3623, subsection B, paragraph 1. (i) Kidnapping. (j) Sexual abuse. (k) Taking a child for the purpose of prostitution as defined in §13-3206. (l) Child prostitution as defined in §13-3212. (m) Involving or using minors in drug offenses. (n) Continuous sexual abuse of a child.

Historical Note

Exhibit N adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT O



ARIZONA DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES
EMERGENCY MEDICAL TECHNICIAN
RECERTIFICATION APPLICATION

1.
LAST NAME:
FIRST NAME:
MI:

2.
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
IS THIS ADDRESS DIFFERENT FROM THE ADDRESS ON YOUR LAST APPLICATION? ☐ YES ☐ NO
PHONE NUMBER: ( ) _____

3. SOCIAL SECURITY NUMBER

4. EMT LEVEL
☐ PARAMEDIC
☐ INTERMEDIATE
☐ INTERMEDIATE WITH DEFIB
☐ BASIC EMT
☐ BASIC EMT WITH IV
☐ BASIC EMT WITH DEFIB
☐ BASIC EMT WITH IV & DEFIB

5. EXAM TYPE
☐ NR ☐ STATE
NOTE: National Registry (NR) requires an addition NR application AND a money order made payable to: NATIONAL REGISTRY OF EMTS. Please see instruction page for additional information.

6. MISDEMEANOR OR FELONY INFORMATION
YES ☐ NO ☐ HAVE YOU EVER BEEN CONVICTED OF A MISDEMEANOR INVOLVING MORAL TURPITUDE OR A FELONY, INCLUDING CONVICTIONS THAT HAVE EXPUNGED OR VACATED, THAT YOU HAVE NOT REPORTED TO A.D.H.S./O.E.M.S. ON A PREVIOUS CERTIFICATION APPLICATION?

7. DRUG USE INFORMATION
YES ☐ NO ☐ DO YOU USE OR HAVE YOU USED WITHIN THE LAST 2 YEARS, ANY ILLEGAL DRUGS OR ANY PRESCRIPTION DRUGS WITHOUT THE SUPERVISION OF A PHYSICIAN?

8. ALCOHOL USE INFORMATION
YES ☐ NO ☐ DO YOU USE OR HAVE YOU USED WITHIN THE LAST 2 YEARS, ALCOHOL TO AN EXTENT THAT IT COULD IMPAIR YOUR ABILITY TO SAFELY FUNCTION AS AN EMT? (SEE TITLE 9, CHAPTER 13 ARIZONA ADMINISTRATIVE CODE FOR EMT FUNCTIONS.)

9. EMS EMPLOYER CODE

11. APPLICANT SIGNATURE
MY SIGNATURE ATTESTS THAT ALL INFORMATION ON THIS APPLICATION IS TRUE AND ACCURATE.
SIGNATURE: _____ DATE: _____

10. BASE HOSPITAL CODE

STAMP

DHS USE ONLY
PHY ☐ CARD ☐ EXAM SITE CODE

SCANTRON FORM NO. F-7888-OEMS

Historical Note
Exhibit O adopted effective October 15, 1996 (Supp. 96-4).

EXHIBIT Q

ARIZONA DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES

APPLICATION FOR EXTENSION OF CERTIFICATION

Applicant's name _____

Certification or OEMS ID number _____ Exp _____

Applicant's address _____

Applicant's phone number _____

EMS Employer _____

EMS Employer's address _____

EMS Employer's phone number _____

I attest, under penalty of perjury, that I was unable to complete the recertification requirements during the effective period of certification for the following reason:

(Check one)

_____ I had a mental or physical disability or health related problem that precluded me from meeting the recertification requirements. Note: You must attach a statement signed by a physician licensed in Arizona verifying this fact.

_____ I was involved in active military duty. Note: You must attach documentation signed by your commanding officer.

_____ I had an undue hardship. Please describe: _____

_____

_____

Note: You must attach a statement from a third party attesting to this.

APPLICANT'S SIGNATURE: _____ DATE: _____

Historical Note
Exhibit Q adopted effective October 15, 1996 (Supp. 96-4).

ARTICLE 7. RESERVED

Editor's Note: Article 8, consisting of Sections R9-25-801 through R9-25-803 and Exhibits, was recodified from A.A.C. R9-13-1501 through R9-13-1503. These recodified Sections were originally filed under an exemption from A.R.S. Title 41, Chapter 6. Refer to the historical notes in 9 A.A.C. 13 for adoption dates (Supp. 98-1).

Article 8, consisting of Section R9-25-805 and Exhibits 1 through 3, was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 36-2205 (C). Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings on this Section. Under A.R.S. § 36-2205 (D) a person may petition the Director to amend an adopted protocol pursuant to A.R.S. § 41-1033 (Supp. 97-2).

ARTICLE 8. MEDICAL DIRECTION PROTOCOLS FOR EMERGENCY MEDICAL TECHNICIANS

(Authority: A.R.S. § 36-2205 (A))

Editor's Note: The following Section was originally adopted under an exemption from the provisions of the Administrative Procedure Act which means that these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R9-25-801. Protocol for Administration of Immunizations by Advanced Life Support Personnel

A. Prior to administering any immunization, the advanced life support personnel shall:
1. Volunteer with or be employed by an agency who sponsors the immunization clinic;
2. Successfully complete an immunization administration training course that meets the standards established in rule;
3. Receive a letter of course completion, signed by the physician who approved the training curriculum, evidencing successful completion of immunization administration training that meets the standards established in rule;
4. Provide evidence of yearly continuing education in immunization administration, as established in rule.

B. The administration of immunizations is not a prehospital emergency service activity. Therefore, the base hospital or administrative medical control authority shall not be responsible for and shall not provide medical direction or control to advanced life support personnel for the administration of immunizations unless it has a separate contract that meets the requirements of subsection (C) of this protocol.

C. The agency which sponsors the immunization clinic and utilizes advanced life support personnel to administer immunizations shall execute a written contract with a physician licensed in Arizona and practicing medicine in general practice, pediatrics, internal medicine, family practice, or emergency medicine. The contract shall authorize the physician to direct the immunization administration activities of the advanced life support personnel. The physician shall:
1. Be accessible by phone, beeper, or in person at the times when immunizations are administered;
2. Approve the training curriculum and either provide each student with a course completion letter or accept a course completion letter signed by another physician evidencing successful completion of immunization administration training.

D. The advanced life support personnel shall:
1. Only administer non-emergent, routine immunizations during a scheduled immunization clinic.
2. Provide the "Immunization Screening Information" sheets, as shown in Exhibit 1, to each recipient who has legal capacity to consent. Provide the sheet to the parent or guardian of a recipient who does not have the legal capacity to consent.
3. Provide each recipient, parent, or guardian with a copy of the "Important Information Statements" as shown in Exhibit 2 which describes the disease, who should receive the vaccine, the vaccine's side effects, and after care for all immunizations the recipient is to receive.
4. Receive written consent for administration of each immunization, on the form shown in Exhibit 3. If the recipient of the immunization has legal capacity to consent, the recipient shall sign the form. If the recipient does not have the legal capacity to consent, the recipient's parent or legal guardian shall sign the form.

E. The authorized immunizations shall include:
1. Oral Polio (OP);
2. Inactivated Polio (IPV);
3. Diphtheria, Pertussis, Tetanus (DPT);
4. Diphtheria, Tetanus (DT);
5. Tetanus, diphtheria (Td);
6. Haemophilus b Conjugate (Hib);
7. Hepatitis B (HBV);
8. Measles, Mumps, Rubella (MMR) or any combination of M, MR, or MMR;
9. Tuberculosis skin test (PPD).

F. The immunizations shall be administered according to the dosage and vaccine administration procedure described in Exhibit 4 to this protocol.

G. Recordkeeping shall be in accordance with A.A.C. R9-6-702(F) and R9-6-703 and statutes mandating immunizations recordkeeping.

Historical Note
R9-25-801 recodified from A.A.C. R9-13-1501 (Supp. 98-1).

Editor's Note: The following Section was originally adopted under an exemption from the provisions of the Administrative Procedure Act which means that these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

R9-25-802. Level of Care

An EMT shall perform only those medical treatments, procedures, and techniques and administer the medications at the level for which the EMT is equipped and certified, following the protocols established pursuant to A.R.S. § 36-2205.

Historical Note
R9-25-802 recodified from A.A.C. R9-13-1502 (Supp. 98-1).

Editor's Note: The following Exhibit was originally adopted under an exemption from the provisions of the Administrative Procedure Act which means that these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

Exhibit 1. Immunization Screening Information - Immunization Program

		YES	NO	DON'T KNOW
1.	Are you or the person being immunized sick with something more serious that a minor illness, such as a cold?			
2.	Have you or the person being immunized ever had a reaction after an immunization that required a visit to the doctor or hospital?			
3.	Are you or the person being immunized allergic to the antibiotics neomycin or streptomycin?			
4.	Are you or the person being immunized allergic to eggs?			
5.	Has the person to be vaccinated or anyone in the household had or have any of the following conditions?			
	• HIV-positive / AIDS			
	• Infections due to immunity problems			
	• Treatment for cancer			
	• Leukemia			
	• Is on a steroid/cortisone medication (prednisone)			
	• Organ transplant			
6.	Have you or the person being immunized received gamma globulin in the past three (3) months?			
7.	Have you or the child to be immunized ever had a serious reaction to a product containing thimerosal (a mercurial antiseptic)?			
8.	Is the girl/woman to be immunized pregnant or plans to become pregnant in the next three (3) months?			

Historical Note

Section R9-25-802, Exhibit 1 recodified from A.A.C. R9-13-1502, Exhibit 1 (Supp. 98-1).

Editor's Note: The following Exhibit was originally adopted under an exemption from the provisions of the Administrative Procedure Act which means that these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

Exhibit 2. Immunization Brochure and Forms

WHAT IS *HAEMOPHILUS INFLUENZAE* TYPE b DISEASE? Haemophilus influenzae type b (Haemophilus b) is a bacterium which can cause serious disease, especially in children under 5 years of age. This bacterium is not the cause of the "flu" (influenza). In the United States, Haemophilus b causes about 12,000 cases of meningitis (infection of the covering of the brain) each year, mostly in children under 5 years of age. About 1 child in every 20 with meningitis caused by Haemophilus b dies of it and about 1 out of 4 has permanent brain damage. Haemophilus b can also cause pneumonia and infections of other body systems such as blood, joints, bone, soft tissue under the skin, throat, and the covering of the heart.

About 1 in every 200 children in the United States will have a moderate to severe disease caused by Haemophilus b before their fifth birthday. Serious Haemophilus b disease is most common in children between 6 months and 1 year of age.

About half of all Haemophilus b disease in children happens during the first year of life. The disease still occurs with some frequency in older preschool children. Thirty percent of severe disease occurs in children 18 months of age or older.

HAEMOPHILUS b CONJUGATE VACCINE: There are at least three types of licensed Haemophilus b conjugate vaccines available for use. All of the vaccines contain the outer coating of the Haemophilus b bacterium which is the part that gives protection against the disease. All of the vaccines are approved for use in children 15 months of age and older. There are some differences among the vaccines. However, all of the vaccines are considered to be effective. Not all of the vaccines are approved for use in infants. The Haemophilus b conjugate vaccine is given by injection. More than 90 percent of infants respond to 3 doses of the vaccine approved for infants by making substances in their blood (antibodies) that provide long-term protection against the severe diseases caused by Haemophilus b bacteria. However, several days are required for any protection to be obtained after immunization. Whether the vaccine provides protection against ear infections caused by Haemophilus b bacteria is not known. It does not protect against disease caused by other types of Haemophilus. The vaccine does not protect against meningitis caused by other bacteria. The vaccine is not known to cause Haemophilus disease. The Haemophilus b conjugate vaccine first became available in 1988 and its use for infants first became recommended in 1990.

WHO SHOULD RECEIVE THE HAEMOPHILUS b CONJUGATE VACCINE?

1. All children should receive the vaccine for infants at 2, 4, and 6 months of age. Also, a dose of any of the approved Haemophilus b conjugate vaccines should be given at 15 months of age, or as soon as possible thereafter.
2. Unvaccinated children 15-60 months of age should receive a single dose of conjugate vaccine.
3. Children 60 months of age and older and adults normally do not need to be immunized.

ARIZONA DEPARTMENT OF HEALTH SERVICES

IMPORTANT INFORMATION ABOUT *HAEMOPHILUS INFLUENZAE* TYPE b DISEASE AND HAEMOPHILUS b CONJUGATE VACCINE

Please read this carefully

I have read or have had explained to me the information on this form about Haemophilus b conjugate vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the Haemophilus b conjugate vaccine and request that it be given to me or to the person named below for whom I am authorized to make this request.

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (Please print)

NAME: Last, First, MI	BIRTHDATE:	AGE:
ADDRESS: STREET	COUNTY:	
CITY:	STATE:	ZIP:
SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST:		DATE:

FOR CLINIC USE

CLINIC IDENTIFICATION:	DATE VACCINATED:
MANUFACTURER AND LOT NO:	SITE OF INJECTION:

POSSIBLE SIDE EFFECTS FROM THE VACCINE:

The Haemophilus b conjugate vaccine has few side effects. Information about the vaccine now available in the United States indicates that about 2 out of every 100 infants who receive the vaccine may have a fever higher than 101° F, 2 out of every 100 may have redness in the area where the vaccine was given; and 1 out of every 100 may have swelling or warmth in the area where the vaccine was given. These reactions begin within 24 hours after the shot is given, but generally go away by 48 hours after immunization. As with any vaccine or drug, there is a rare possibility that other serious problems or even death could occur after receiving the Haemophilus b conjugate vaccine.

WARNING-SOME PERSONS SHOULD NOT TAKE THIS VACCINE WITHOUT CHECKING WITH A DOCTOR:

- Anyone who is sick right now with something more serious than a minor illness such as a common cold.
- Anyone who has had a serious reaction to a product containing thimerosal, a mercurial antiseptic included in one of the vaccines that is in use.
- Anyone who has had an allergic reaction to a vaccine containing diphtheria toxoid so serious that it required medical treatment.

QUESTIONS If you have any questions about Haemophilus b disease or Haemophilus b conjugate vaccine, please ask now or call your doctor or health department before you sign this form.

WHAT TO LOOK FOR AND DO AFTER THE VACCINATION:

As with any serious medical problem, if the person has a serious or unusual problem after getting the vaccine, call a doctor or get the person to a doctor promptly.

If the person who received the conjugate vaccine gets sick and visits a doctor, hospital, or clinic during the 4 weeks after immunization, please report it to:

Please read this pamphlet before you or your child gets a vaccine!

Before vaccines were available, most children caught pertussis. Also, hundreds of people became ill with tetanus each year and thousands became ill with diphtheria.

The benefits of the vaccines to prevent these three diseases are greater than the possible risks for almost all people. A person who receives vaccines benefits from the protection they provide. When many people are vaccinated, everyone benefits because the chance for spread of disease is reduced.

These diseases may cause serious health problems. Therefore, it is important to be protected by vaccine shots. Usually, the vaccines for all three diseases are combined and are given together as one shot. This is called the DTP vaccine. DTP vaccine is usually given 5 times before a child reaches age 7 years.

Every vaccine has risks as well as benefits. Most problems that happen after receiving vaccines are mild, but a few people will have a serious problem. While most infants and children under 7 years of age should get the DTP, a few should delay getting this vaccine and a few others should get the DT vaccine (diphtheria and tetanus vaccine) instead. Another tetanus and diphtheria vaccine (Td) is used to protect older children and adults. Tetanus vaccine (T) is still used by some doctors, but the combined Td vaccine is recommended by most experts.

This pamphlet tells you more about:

The diseases diphtheria, tetanus, and pertussis	page 1
The benefits of the vaccines	page 2
The risks of the vaccines	page 3
When your child should routinely get vaccines	page 4
When your child should delay getting or not get the DTP vaccine	pages 5 & 6
What to look for and to do after the shot	pages 7 & 8

WHAT ARE THESE DISEASES?

PERTUSSIS, sometimes called **whooping cough**, may be a mild or serious disease. It is very easily passed from one person to another. Pertussis can cause spells of coughing and choking that make it hard to eat, drink, or breathe. The coughing can last for several weeks.

The information on pertussis that follows is based on cases that were reported from doctors and health-care providers. In recent years, as many as 4,200 cases of pertussis have been reported yearly in the United States and outbreaks still occur. Many cases, including those with less serious illness, do not get reported.

Pertussis is most dangerous to babies (children less than 1 year old). Even with modern medical care, complications occur. About half of the babies reported to have pertussis are so sick that they must go into the hospital. As many as 16 out of 100 babies with pertussis get pneumonia, and as many as 2 out of 100 may have convulsions (seizures, fits, spasms, twitching, jerking, or staring spells). About 1 baby out of 200 has brain problems that may last all his or her life. About 1 out of every 200 babies with pertussis dies of it. Serious illness is less likely in older children and adults.

DIPHTHERIA is a very serious disease. It can make a person unable to breathe, cause paralysis, or heart failure. About 1 out of every 10 people who get diphtheria dies of it.

Only a few cases of diphtheria were reported in the United States during the past few years. This is mostly because people have had shots to protect them.

TETANUS, sometimes called **lockjaw**, is a very serious disease that can occur after a cut or wound lets the germ into the body. Tetanus makes a person unable to open his or her mouth or swallow, and causes serious muscle spasms. People with tetanus usually have to stay in the hospital for a long time. In the United States, tetanus kills 3 out of every 10 people who get the disease. Since 1975, only 50 to 90 cases of tetanus have been reported each year.

Almost no cases occur in children or young adults because children and young adults have taken the shots and are usually protected.

WHAT ABOUT THE VACCINES AND THEIR BENEFITS?

The vaccines to protect children younger than 7 years old against all 3 diseases are usually given together as one shot. This is called the **DTP** vaccine (**D**iphtheria, **T**etanus, and **P**ertussis). Most children should get 5 DTP shots before they go to school. Most babies should get 3 DTP shots by 6 months of age.

Three or more DTP shots keep:

- 70 to 90 children out of 100 from getting **pertussis** if exposed to it, and usually protect the child through the elementary school years. The others who have had the DTP vaccine but get pertussis usually have a milder illness than if they had not had the vaccine.
- At least 85 children out of 100 from getting **diphtheria** for at least 10 years.
- At least 95 children out of 100 from getting **tetanus** for at least 10 years.

Pertussis vaccine should not be given to a few children. Other vaccines are available for these children and for adults:

- DT vaccine (Diphtheria and Tetanus) is given to children under age 7 years who should not receive pertussis vaccine.
- Td vaccine (Tetanus and diphtheria) is specially made for children age 7 years and older and for adults.

WHAT ARE THE RISKS OF THESE VACCINES?

DTP

Most children have little or no problem from the DTP shot. Many children will have fever or soreness, swelling, and redness where the shot was given. Usually these problems are mild and last 1 to 2 days. Some children will be cranky, drowsy, or not want to eat during this time.

Less often -- that is, following 1 DTP shot in 100 to 1 shot in 1,000 -- a more serious problem can happen:

- Crying without stopping for 3 hours or longer
- A temperature of 105° F or higher
- An unusual, high-pitched cry

Even less often -- following 1 DTP shot in 1,750 -- a child may have:

- A convulsion (seizures, fits, spasms, twitching, jerking, or staring spells), usually from high fever that may happen after the shot
- Shock-collapse (become blue or pale, limp, and not responsive)

Rarely, brain damage that lasts for the child's life has been reported after getting DTP. However, most experts now agree that DTP has not been shown to be a cause of brain damage. If DTP ever causes brain damage, then such an event would be very rare. There is no test that can tell in advance if your child will have any of these problems following DTP vaccination.

DT, Td, and T

DT, Td, and T vaccines cause few problems. They may cause mild fever or soreness, swelling, and redness where the shot was given. These problems usually last for 1 to 2 days, but this does not happen nearly as often as with DTP vaccine. Sometimes, adults who get these vaccines too often can have a lot of soreness and swelling where the shot was given.

There is a rare chance that other serious problems or even death could occur after getting DTP, Pertussis, DT, T, or Td. Such problems could happen after taking any medicine or after receiving any vaccine.

WHEN SHOULD YOUR CHILD GET THE DTP VACCINES AND OTHER VACCINES?

Below are **all** of the vaccines that most infants and children should get and the age when most experts suggest they should get each dose of vaccine.

RECOMMENDED SCHEDULE OF VACCINATIONS FOR ALL CHILDREN							
Vaccine		**2 Months**	**4 Months**	**6 Months**	**12 Months**	**15 Months**	**4-6 Years** (Before School Entry)
DTP		DTP	DTP	DTP		DTP*	DTP
POLIO		POLIO	POLIO			POLIO*	POLIO
MMR						MMR†	MMR¶
HIB Option 1§ Option 2§		 HIB HIB	 HIB HIB	HIB	 HIB	HIB	
Vaccine	**Birth**	**1-2 Months**	**4 Months**	**6-18 Months**			
HB Option 1 Option 2	HB	 HB‡ HB‡	 HB‡	 HB‡ HB‡			

DTP: Diphtheria, Tetanus, and Pertussis Vaccine
Polio: Live Oral Polio Vaccine drops (OPV) or Killed (Inactivated) Polio Vaccine shots (IPV)
MMR: Measles, Mumps, and Rubella Vaccine
HIB: Haemophilus b Conjugate Vaccine
HB: Hepatitis B Vaccine
* Many experts recommend these vaccines at 18 months.
† In some areas this dose of MMR vaccine may be given at 12 months.
¶ Many experts recommend this dose of MMR vaccine be given at entry to middle school or junior high school.
§ HIB vaccine is given in either a 4-dose schedule (1) or a 3-dose schedule (2), depending on the type of vaccine used.
‡ Hepatitis B vaccine can be given simultaneously with DTP, Polio, MMR, and *Haemophilus b* Conjugate Vaccine at the same visit.

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ARE THE BENEFITS OF THE VACCINES GREATER THAN THE RISKS?

Yes, for almost all people.

Children, especially infants, who catch pertussis are often seriously ill. People with diphtheria or tetanus usually are seriously ill. Most people who have had 3 or more shots of DTP are protected from these diseases for many years. If children have the DTP shots but get pertussis, the illness is usually milder than if they had not had the shots. The number of children who have had a serious problem after receiving DTP is unknown, but is probably very small.

Experts believe that most children should receive DTP shots. If a child should not receive DTP, the child should usually receive DT. After reading this pamphlet and talking with your doctor or nurse, you can decide together what is best for your child.

WHEN SHOULD A SHOT BE DELAYED?

There are several reasons for a child to delay getting the DTP shot. If the child:

- Is sick with something more serious than a minor illness such as a common cold, delay the vaccination until your child is better.
- Has **ever** had a convulsion or other brain problem or seems not to be developing normally (until it is clear that your child is not getting worse or having more convulsions).

Such children should be carefully examined by a doctor before a decision is made.

If your child is sick or if you are not sure if a shot should be delayed, talk to your doctor or nurse. Then you can decide together what is best for your child.

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WHEN SHOULD THE DTP VACCINE NOT BE GIVEN?

Your child should not get another DTP shot if any of the problems listed below happened after an earlier DTP and had no other obvious cause. Talk with your doctor or nurse about any of these problems.

- Serious problems of the brain ***within 7 days*** after getting DTP.
- Serious allergic problem (swelling in the mouth, throat, or face, or difficulty breathing) ***within a few hours*** after getting DTP.
- The presence of a brain problem that is getting worse, such as uncontrolled convulsions.

Many experts believe that a child should not get another DTP shot if any of the problems listed below happened after an earlier DTP shot and had no other obvious cause. However, for some children, the benefits outweigh the risks. Talk with your doctor or nurse about any of these problems.

- Temperature of 105° F or higher ***within 2 days*** after getting DTP.
- Shock-collapse (becoming blue or pale, limp and not responsive) ***within 2 days*** after getting DTP.
- Convulsion ***within 3 days*** after getting DTP.
- Crying that cannot be stopped and which lasts for more than 3 hours at a time ***within the 2 days*** after getting DTP.

If you know or think that any of these problems happened after getting DTP, tell a doctor or nurse before that child receives another DTP or any other vaccine. If a child should not be given DTP, usually the child should get DT vaccine instead.

SHOULD PREGNANT WOMEN RECEIVE Td?

Babies born under unclean conditions to women who have no protection against tetanus have an increased risk of getting tetanus as newborns. This can be prevented by giving Td vaccine to women. Women who have not received Td or T earlier should be given the vaccine when they are pregnant.

Td and T vaccines are not known to cause special problems for pregnant women or their unborn babies. While doctors usually do not recommend giving any drugs or vaccines to pregnant women, a pregnant woman who needs Td vaccine should get it.

WHICH CHILDREN MAY BE MORE LIKELY TO HAVE A CONVULSION AFTER RECEIVING DTP?

The chance of a child having a convulsion with fever after receiving DTP vaccine is up to 9 times greater if the child has had a convulsion before. It is about 3 times greater if the child's brother, sister, or parent has ever had a convulsion.

Most experts agree that unless the convulsion occurred within 3 days after getting DTP vaccine, children who have had a convulsion should still get the DTP vaccine. Also children who have a family member who has had a convulsion should get the DTP vaccine.

It is usually the fever that causes the convulsion. Most experts believe that convulsions with fever do not cause any permanent damage to the child.

Be sure to tell the doctor or nurse who is giving the shot about any history of convulsions. Talk with them about the medicines or other measures to reduce fever and soreness from the vaccines.

WHAT TO LOOK FOR AND TO DO AFTER THE SHOT

Talk with the doctor or nurse who gives the shot about taking medicines or other measures to reduce fever and soreness from the vaccine.

This pamphlet lists the problems (on pages 3, 6, and 7) that may occur after receiving DTP or other si-lots for diphtheria, tetanus, or pertussis.

As with any serious medical problem, if the person has a serious or unusual problem after getting the vaccine, **CALL A DOCTOR OR GET THE PERSON TO A DOCTOR PROMPTLY.**

If you or your child does have a reaction to the vaccine, you can help your doctor by writing down exactly what happened.

Use this form or write on a piece of paper exactly what happened, what day it happened, and the time it happened.

Type of Vaccine and Date Received: _____

Problems	**Day and Time Problem Started**

HAVE THE PROBLEM REPORTED:

The Public Health Service is interested in finding out if any serious problems may be related to DTP, Pertussis, DT, T, or Td vaccines, especially those that occur within 4 weeks after the shot.

If you believe that the person receiving the vaccine had a serious problem or died because of the shot:

Call this number:

And ask the doctor or health department to report the problem on a Vaccine Adverse Event Report form.

If you think the problem was not reported, you should report the problem yourself. You can get the form by calling this toll-free number: **1-800-822-7967**.

GET INFORMATION ABOUT POSSIBLE HELP:

A U.S. government program provides compensation for some persons injured by vaccines. For more information, call this toll-free number:

1-800-338-2382

OR contact:

The U.S. Claims Court
717 Madison Place, NW
Washington, DC 20005

(202) 633-7257

Please read this pamphlet before you or your child gets a dose of vaccine!

As recently as the 1950s, polio was a common disease in the United States. Parents feared this disease for good reasons. In 1952, more than 20,000 people were paralyzed by polio. Because children and adults now receive vaccines, there are only a few cases of polio each year in the United States.

The benefits of polio vaccine are greater than any possible risks for almost all people. A person who receives vaccines benefits from the protection they provide. When many people are vaccinated everyone benefits because the chance of spreading the disease is reduced.

Every vaccine and medicine has risks as well as benefits. Most vaccine reactions are mild. But a few people may get very sick after getting vaccines. Some should not get the polio vaccine or should delay getting it.

There are 2 kinds of vaccines that can protect you or your child against polio. Read this pamphlet before you or your child gets the vaccine. Talk it over with your doctor or nurse. Then, together, you can decide what is best for you or your child.

This pamphlet tells you more about:

The disease polio	page 1
The benefits of the vaccines	page 2
The risks of the vaccines	page 3
When your child should routinely get vaccines	page 4
When the vaccines should be delayed or not be given	page 6
What to look for and to do after getting the polio vaccine	pages 7 & 8

WHAT IS POLIO?

Polio is a very dangerous disease caused by a virus. Some children and adults who get a serious case of polio become paralyzed. This means that they are unable to move parts of their bodies. They may even die from the disease.

The serious cases of polio cause severe muscle pain and sometimes make the person unable to move one or both legs or arms and may make it difficult to breathe without the help of a machine, Mild cases of polio may last only a few days and may cause the person to have fever, sore throat, stomachache, and headache.

There are no drugs or other special treatments that will cure people who get polio. How sick people get with the disease and how much they recover are different for each person. Most people who are paralyzed by polio will have some weakness in an arm or leg for the rest of their lives. Many of these people will be seriously disabled.

Although there are few cases of polio in the United States now, there are still many thousands of cases of polio each year in other countries. Therefore, it is important to protect our children with vaccines so that they cannot get the disease when someone brings the virus into the United States from another country.

WHAT ABOUT THE VACCINES AND THEIR BENEFITS?

There are 2 types of polio vaccines. Most experts recommend the live **o**ral **p**olio **v**accine, which is called **OPV**. "Live" means that the polio virus used in the vaccine is still alive but has been made very weak. This type of vaccine is given as drops in the mouth. The other vaccine is called **IPV** (**i**nactivated **p**olio **v**accine). "Inactivated" means that the polio virus used in the vaccine has been killed. This type of vaccine is given as a shot.

At least 90 out of every 100 people who get 3 or more doses of either OPV or IPV will be protected against polio. For healthy children and teenagers up to their 18th birthday, most experts recommend OPV drops rather than IPV shots. This is because OPV is easier to take and is more effective in preventing the spread of polio.

The best way to be protected against polio is to get 4 doses of polio vaccine. Most babies should get 2 doses by 4 months of age and a third dose at 15 to 18 months of age. The fourth dose is given at 4 to 6 years of age.

These doses may be the drops given in the mouth (OPV) or the shots (IPV).

If there is a case of polio in your neighborhood or where your child goes to school or child-care, your child may need another dose of vaccine. Your doctor may also suggest that your child get another dose before taking a trip to any country where polio is common.

Adults who are doing to countries where polio is common should also get at least one dose of either OPV (it they have had this type of vaccine before) or IPV. If an adult has never had OPV, he or she should get IPV. It would be best to get 3 doses before going. If there is only enough time to get one dose, either OPV or IPV should be given before leaving the country.

WHAT ARE THE RISKS OF THESE VACCINES?

Both OPV and IPV vaccines cause problems in very few people.

OPV drops:

- Very rarely, OPV causes polio ***in the person who gets the drops.***
- ***For the person who gets the vaccine,*** the chance of becoming paralyzed is higher after getting the first dose of vaccine than after the second, third, or fourth doses. Paralysis after the first dose happens about once for every 1 ½ million doses of drops given. But paralysis after later doses happens only about once for every 40 million doses given.
- OPV drops very rarely can cause polio ***in people who are in close contact with the person who gets the vaccine.*** This happens only to people not already protected by polio vaccine.
- The chance of ***a person in close contact with the one who gets the vaccine*** becoming paralyzed is higher after the first dose of vaccine than after the second, third, or fourth doses. Paralysis after the first dose happens about once for every 2 million doses of drops given. But paralysis after later doses happens only about once for every 14 million doses given. If the parent or other adult household contact of a child receiving OPV has never received polio vaccine, this person should consider, if possible, being vaccinated with IPV before or at the same time as the child. Vaccination of the child should not be delayed. Talk with your doctor or nurse if you have any questions.

IPV shots:

- IPV can cause a little soreness and redness where the shot was given.

There is a very rare chance that other serious problems or even death could occur after getting either vaccine. Such problems could happen after taking any medicine or after receiving any vaccine.

WHEN SHOULD YOUR CHILD GET THE POLIO VACCINE AND OTHER VACCINES?

Below are **all** of the vaccines that most infants and children should get and the age when most experts suggest they should get each dose of vaccine.

RECOMMENDED SCHEDULE OF VACCINATIONS FOR ALL CHILDREN

Vaccine		**2 Months**	**4 Months**	**6 Months**	**12 Months**	**15 Months**	**4-6 Years**
							(Before School Entry)
DTP		DTP	DTP	DTP		DTP*	DTP
POLIO		POLIO	POLIO			POLIO*	POLIO
MMR						MMR†	MMR¶
HIB Option 1§ Option 2§		 HIB HIB	 HIB HIB	HIB	 HIB	HIB	
Vaccine	**Birth**	**1-2 Months**	**4 Months**	**6-18 Months**			
HB Option 1 Option 2	HB	 HB‡ HB‡	 HB‡	 HB‡ HB‡			

DTP: Diphtheria, Tetanus, and Pertussis Vaccine
Polio: Live Oral Polio Vaccine drops (OPV) or Killed (Inactivated) Polio Vaccine shots (IPV)
MMR: Measles, Mumps, and Rubella Vaccine
HIB: Haemophilus b Conjugate Vaccine
HB: Hepatitis B Vaccine
* Many experts recommend these vaccines at 18 months.
† In some areas this dose of MMR vaccine may be given at 12 months.
¶ Many experts recommend this dose of MMR vaccine be given at entry to middle school or junior high school.
§ HIB vaccine is given in either a 4-dose schedule (1) or a 3-dose schedule (2), depending on the type of vaccine used.
‡ Hepatitis B vaccine can be given simultaneously with DTP, Polio, MMR, and Haemophilus b Conjugate Vaccine at the same visit.

ARE THE BENEFITS OF THE VACCINES GREATER THAN THE RISKS?

Yes, for almost all people.

Polio can be a very serious disease. Almost all people who get the vaccines are protected from this disease. Only a small number of people have problems after getting the vaccines. The problems that may happen after receiving vaccine occur much less often than when the person has the disease.

Experts believe that most people should receive polio vaccine. After reading this pamphlet and talking with your doctor or nurse, you can decide whether there is any reason for you or your child to delay or not get the polio vaccine.

There are several reasons why some people may need to delay getting polio vaccine or should not get it at all.

WHEN SHOULD THE VACCINES BE DELAYED?

Polio drops (OPV) **or** shots (IPV) should be delayed for any person who:

- Is sick with something more serious than a minor illness such as a common cold. Delay the vaccination until the person is better.

WHEN SHOULD THE VACCINES NOT BE GIVEN?

IPV should be given instead of OPV to a person who:

- Is born with or develops any disease that makes it hard for the body to fight infection, such as cancer, leukemia, or lymphoma (cancer of the lymph glands),
- Has AIDS or infection with the virus that causes AIDS.
- Is taking special cancer treatments such as x-rays or drugs or is taking other drugs, such as prednisone or steroids, that make it hard for the body to fight infection.

The close contact that occurs in the home makes it possible for the virus that is present in OPV drops to be passed on to another member of the household. Doctors usually advise that if any person in the home has any of the medical conditions listed above, IPV should be used instead of DPV.

IPV should not be given to a person who:

- Has had an allergy problem with the antibiotics **neomycin** or **streptomycin** so serious that it required treatment by a doctor.

Be sure to talk to the doctor or nurse about which polio vaccine you or your child should get.

SHOULD PREGNANT WOMEN RECEIVE THE VACCINES?

The polio vaccines are not known to cause any problems to the unborn babies of pregnant women. Doctors usually do not recommend giving any drugs or vaccines to pregnant women unless there is a special need. However, if a pregnant woman needs immediate protection, OPV is recommended.

WHAT TO LOOK FOR AND TO DO AFTER GETTING THE POLIO VACCINE:

This pamphlet lists the problems (on pages 3, 6 and 7) that may occur after receiving either OPV or IPV.

As with any other serious medical problem, if the person has a serious or unusual problem after getting the vaccine, **CALL A DOCTOR OR GET THE PERSON TO A DOCTOR PROMPTLY.**

Please read this pamphlet before you or your child gets a vaccine!

Before vaccines were available to protect against measles, mumps, and rubella, nearly everyone caught these diseases while growing up. The use of vaccines against these diseases has greatly reduced the number of people getting these illnesses.

The benefits of the vaccines to prevent these three diseases are greater than the possible risks for almost all people. A person who receives vaccines benefits from the protection they provide. When many people are vaccinated, everyone benefits because the chance for spread of disease is reduced.

Serious health problems are caused by these diseases. Therefore, it is important to be protected by the vaccines. Usually, vaccines for all 3 diseases are combined and are given together as 1 shot, called the MMR vaccine. Usually it is given 2 times, first at 15 months of age and again before school entry (4 to 6 years of age), or before entering middle school or junior high school.

Every vaccine and medicine has both benefits and risks. Most problems that occur after vaccines are mild, but a few people may have a serious problem. While most people should get MMR, a few people should not, and a few others should delay getting the vaccine.

This pamphlet tells you more about:

The diseases measles, mumps, and rubella	pages 1 & 2
The benefits of the vaccines	page 2
The risks of the vaccines	pages 3 & 4
When your child should routinely get vaccines	page 5
When the vaccines should be delayed or not be given	page 6
What to look for and to do after the shot	pages 7 & 8

WHAT ARE THESE DISEASES?

MEASLES is a serious disease. It is very easily passed from one person to another. It causes a high fever, cough, and a rash and lasts for 1 to 2 weeks. In recent years, 3,000 to 28,000 cases of measles have been reported yearly in the United States and outbreaks still occur. One out of every 10 children who catch measles will also have an ear infection or pneumonia.

Measles can also cause an infection of the brain that could lead to convulsions (seizures, fits, spasms, twitching, jerking, or staring spells), hearing loss, and mental retardation. This happens to about 1 out of every 1,000 children reported to have the disease. In the United States, 1 child out of every 500 to 10,000 who gets measles dies from it.

Babies and adults who catch measles are often much sicker and are more likely to suffer longer or die than elementary school children and teenagers with measles.

MUMPS causes fever, headache, and swollen, painful glands under the jaw. Mumps sometimes can be a very serious disease. It lasts for several days and it is easily passed from person to person. In recent years, 4,500 to 13,000 cases of mumps have been reported each year in the United States and outbreaks still occur.

Mumps can cause a mild inflammation of the coverings of the brain and spinal cord (meningitis) in about 1 person in every 10 who get it. Swelling or inflammation of the brain is reported in about 1 case out of every 200. Before there was a mumps vaccine, many children had hearing loss caused by mumps. About 1 out of every 4 teenage or adult males with mumps will have a painful swelling of the testicles for several days. This usually does not make the person unable to father children.

Teenagers and adults, especially males, who catch mumps are often much sicker and more likely to suffer longer than children do.

RUBELLA is also called German measles. In recent years, only a few hundred cases of rubella were reported each year. It is usually a mild disease that lasts for a short time. **BUT if a pregnant woman catches the disease**, rubella is very dangerous to her unborn baby. Up to half of the women who catch rubella when they are pregnant will lose their babies or have babies born with heart disease, or babies who will be blind or deaf, or who have problems with learning. In the United States, before there was a rubella vaccine, many thousands of babies with these serious health problems were born to mothers who caught rubella while they were pregnant.

People who catch rubella usually have mild fever, swollen glands in the neck, and a rash that lasts up to 3 days. Rubella may cause soreness in the joints and swelling of the joints (arthritis). This may happen in up to 70 out of every 100 women. Usually this lasts only for a week or two but in rare cases it may last for months or years, or may come and go.

People who do not get the rubella vaccine are in danger of catching rubella and passing it on to a pregnant woman. About 1 out of every 10 women in the United States is not protected against rubella.

WHAT ABOUT THE VACCINES AND THEIR BENEFITS?

The vaccines to protect against all 3 diseases are usually given together in 1 shot, called the MMR vaccine. One MMR shot protects 90 to 98 people out of every 100 against **measles**, **mumps**, and **rubella** if they get the vaccine at the right age. Usually a child gets the first MMR at 15 months of age, but sometimes it should be given at 12 months of age, or even earlier during an outbreak. To protect the few children not protected by the first MMR, a second MMR is recommended when a child enters school for the first time or when a child enters middle school or junior high school.

These vaccines protect nearly all people for a very long time, probably for life. However, if an outbreak of measles occurs, doctors may recommend a second MMR shot. Teenagers and adults who do not know if they are protected against these diseases should ask their doctor or clinic about getting the MMR.

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WHAT ARE THE RISKS OF THESE VACCINES?

Most people who get the MMR vaccine will not have a problem. Others will have minor problems such as a sore or red arm that lasts for 1 to 2 days. Rarely a person may have a serious problem.

If you or your child receives the MMR, there is a chance that any of the problems listed below could happen. If problems occur, they almost always happen after the first shot. If you or your child receives only the measles vaccine, or the mumps vaccine, or the rubella vaccine, you should only look for the problems listed for the vaccine received

Mild or Moderate Problems From the Vaccines

MEASLES VACCINE:

- A rash may occur from 1 to 2 weeks after receiving the measles vaccine About 5 children out of every 100 will get a rash.
- A fever of 103° F or higher after receiving the first shot of measles vaccine, even though the child may not act sick. About 5 to 15 young children out of every 100 who receive the vaccine get such a fever. This could happen from 1 to 2 weeks after receiving the vaccine and usually lasts 1 or 2 days. The fever occurs less often after a second shot.

MUMPS VACCINE:

- A little swelling of the glands in the cheeks and under the jaw that lasts for a few days. This could happen from 1 to 2 weeks after getting the mumps vaccine. This happens rarely.

RUBELLA VACCINE:

- Swelling of the lymph stands in the neck or a rash that lasts 1 or 2 days. This could happen 1 to 2 weeks after getting the rubella vaccine in about 1 child out of every 7 who get the vaccine.
- Mild pain or stiffness in the joints that may last up to 3 days. This could happen from 1 to 3 weeks after getting the shot. This problem happens to about 1 child out of every 100 who get the shot and to about 25 adults out of every 100. Women have this problem more than men and it may happen in up to 40 women out of every 100. Rarely, pain or stiffness can last for months or longer and can come and go.

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- Painful swelling of the joints (arthritis) happens to fewer than 1 child out of every 100 who get the rubella vaccine. About 10 adults out of every 100 can also have this problem, which usually lasts a few days to a week. Rarely, this swelling has been reported to last longer, or to come and go. Damage to the joints is very rare.
- Pain or numbness, or "pins and needles" feeling in the hands and feet that lasts for a short time. This happens rarely.

More Serious Problems From These Vaccines

- Children 6 months through 6 years of age who get the vaccines can, in rare cases, have a brief convulsion (fits, seizures, spasms, twitching, jerking, or staring spells). This usually occurs 1 to 2 weeks later and usually comes from the fever caused by the measles vaccine. Very rarely, hearing loss has been reported, but it is not known whether hearing loss is ever caused by these vaccines. Very rarely, a person can have inflammation of the brain after receiving the vaccine. This usually clears up completely. These brain problems have been reported to happen about 1 time for every million MMR shots given.
- There is a rare chance that other serious problems and even death could occur after getting the vaccines. Such problems could happen after taking any medicine or after receiving any vaccine.

ARE THE BENEFITS OF THE VACCINES GREATER THAN THE RISKS?

Yes, for almost all people.

These diseases make some people very ill. Almost all people who get the vaccines are protected from these diseases. A small number of people have problems after getting the vaccines. The problems that may happen after receiving the vaccine occur much less often than when a person has the disease.

Experts believe that most people should receive these vaccines. After reading this pamphlet and talking with your doctor or nurse, you can decide whether there is any reason for you or your child to delay getting or not get the vaccine.

WHEN SHOULD YOUR CHILD GET THE MMR VACCINES AND OTHER VACCINES?

Below are **all** of the vaccines that most infants and children should get and the age when most experts suggest they should get each dose of vaccine.

RECOMMENDED SCHEDULE OF VACCINATIONS FOR ALL CHILDREN

Vaccine		**2 Months**	**4 Months**	**6 Months**	**12 Months**	**15 Months**	**4-6 Years**
							(Before School Entry)
DTP		DTP	DTP	DTP		DTP*	DTP
POLIO		POLIO	POLIO	POLIO		POLIO*	POLIO
MMR						MMR†	MMR¶
HIB Option 1§ Option 2§		 HIB HIB	 HIB HIB	HIB	 HIB	HIB	
Vaccine	**Birth**	**1-2 Months**	**4 Months**	**6-18 Months**			
HB Option 1 Option 2	HB	 HB‡ HB‡	 HB‡	 HB‡ HB‡			

DTP: Diphtheria, Tetanus, and Pertussis Vaccine
Polio: Live Oral Polio Vaccine drops (OPV) or Killed (Inactivated) Polio Vaccine shots (IPV)
MMR: Measles, Mumps, and Rubella Vaccine
HIB: Haemophilus b Conjugate Vaccine
HB: Hepatitis B Vaccine
* Many experts recommend these vaccines at 18 months.
† In some areas this dose of MMR vaccine may be given at 12 months.
¶ Many experts recommend this dose of MMR vaccine be given at entry to middle school or junior high school.
§ HIB vaccine is given in either a 4-dose schedule (1) or a 3-dose schedule (2), depending on the type of vaccine used.
‡ Hepatitis B vaccine can be given simultaneously with DTP, Polio, MMR, and Haemophilus b Conjugate Vaccine at the same visit.

WHEN SHOULD THE VACCINES BE DELAYED OR NOT BE GIVEN?

There are several reasons some people may need to delay getting the MMR vaccine or not get the shot at all. These reasons also apply to measles vaccine, mumps vaccine, and rubella vaccine.

Tell the doctor or nurse if the person who is going to get the vaccine:

- Is sick with something more serious than a minor illness such as a common cold. Delay the vaccination until the person is better.
- Has ever had an allergy problem after eating eggs that was serious enough to require the attention of a doctor. This does not matter if the person is only receiving the rubella vaccine.
- Has had an allergy problem to an antibiotic called neomycin so serious that it required treatment by a doctor.
- Is born with or develops any disease that makes it hard for the body to fight infection such as cancer, leukemia, lymphoma (cancer of the lymph glands).
- Is taking special cancer treatments such as x-rays or drugs, or is taking other drugs such as prednisone or steroids that make it hard for the body to fight infection.
- Has received gamma globulin during the past 3 months.
- Is pregnant or thinks she is pregnant.

All people who do not get the vaccine because of one of the reasons listed above should check again with the doctor or nurse about getting the vaccines at a later time.

SHOULD PREGNANT WOMEN RECEIVE THE VACCINES?

Women who are pregnant, who think they are pregnant, or who might get pregnant in the next 3 months, should not get MMR or other vaccines for measles, mumps, or rubella. This is recommended even though these vaccines are not known to cause problems for pregnant women or their unborn babies. It is safe, however, to give a shot to a child whose mother is pregnant.

If a woman is pregnant and does not know if she is protected against rubella, she should tell her doctor. A woman who receives any of these vaccines should not get pregnant for the next 3 months. A woman who needs protection against any of these diseases should be given the vaccines right after her baby is born.

WHICH PEOPLE MAY BE MORE LIKELY TO HAVE A CONVULSION AFTER RECEIVING MMR?

The chance of a child having a convulsion with fever after receiving measles vaccine is small. However, the risk is up to 5 times greater if the child has ever had a convulsion before. It is also greater if the child's brother, sister, or parent has ever had a convulsion.

Most experts agree that people who have had a convulsion should still get the MMR vaccine. Also, people who have a family member who has had a convulsion should get the MMR vaccine.

The overall chance of convulsion after getting the vaccine is still rare. It is usually the fever that causes the convulsion. Most experts believe that convulsions with fever do not cause any permanent damage to the child.

Be sure to tell the doctor or nurse who is giving the shot about any history of convulsions. Talk with them about medicines or other ways you can reduce fever from the shot.

If there was a problem after receiving the first MMR or separate shots for measles, mumps, or rubella, be sure to tell the doctor or nurse before receiving a second shot of the vaccine.

WHAT TO LOOK FOR AND TO DO AFTER THE SHOT

Talk with the doctor or nurse who gives the shot about medicines or other ways you can treat fever from the vaccine.

This pamphlet lists the problems (on pages 3, 4, 6, and 7) that may occur after receiving MMR or other shots for measles, mumps, or rubella.

As with any serious medical problem, if the person has a serious or unusual problem after getting the vaccine, **CALL A DOCTOR OR GET THE PERSON TO A DOCTOR PROMPTLY.**

If you or your child does have a reaction to the vaccine, you can help your doctor by writing down exactly what happened.

Use this form or write on a piece of paper exactly what happened, what day it happened, and the time it happened.

Type of Vaccine and Date Received: _____

Problems	Day and Time Problem Started

8

HAVE THE PROBLEM REPORTED:

The Public Health Service is interested in finding out if any serious problems may be related to MMR, measles-rubella, measles, mumps, or rubella vaccines, especially those that occur within 4 weeks after the shot.

If you believe that the person receiving the vaccine had a serious problem or died because of the shot:

Call this number:

And ask the doctor or health department to report the problem on a Vaccine Adverse Event Report form.

If you think the problem was not reported, you should report the problem yourself. You can get the form by calling this toll-tree number: **1-800-822-7967.**

GET INFORMATION ABOUT POSSIBLE HELP:

A U.S. government program provides compensation for some persons injured by vaccines. For more information, call this toll-free number:

1-800-338-2382

OR contact:

The U.S. Claims Court
717 Madison Place, NW
Washington, DC 20005

(202) 633-7257

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Important Information About Hepatitis B, Hepatitis B Vaccine, and Hepatitis B Immune Globulin

Editor's Note: This portion of Exhibit 2 was partially illegible as submitted to the Secretary of State's Office for publication. Therefore, this information is not reprinted here. For copies of this information, please contact the Department of Health Services.

Department of Health Services - Emergency Medical Services

Arizona Department of Health Services

INFORMATION AFTER IMMUNIZATIONS

(Name) _____ has just received the following immunization(s) (date) _____.

Parent or Guardian: Remember to inform your child's School or Child Care Center that this immunization has been received

[ ] DTP (Diphtheria, Tetanus, Pertussis) [ ] DT (Diphtheria, Tetanus)
[ ] Td (Tetanus, Diphtheria-adult).

< > During the first 2 days following immunization, slight fever, irritability, local redness and/or tenderness at site of injection are common. Give extra fluids. Call your doctor or hospital if your child develops any more serious reactions such as fever over 105° F, abnormal crying for several hours or convulsions. If there is a family history of convulsions in parents or brothers or sisters, give a non-aspirin fever medication when vaccine is received and every 4 to 6 hours for 48-72 hours.

[ ] OPV (Oral Polio Vaccine)

< > This vaccine rarely produces side effects. Polio virus is shed in the stool for 6 weeks. Wash your hands carefully after diaper changes or assisting with toileting.

IPV (Inactivated Polio Vaccine)

< > No anticipated reaction.

MMR (Measles, Mumps, Rubella)

Measles < > A non-contagious rash and/or slight fever may occur 1-2 weeks following immunization. Give extra fluids for fever.

Mumps < > No specific treatment recommended.

Rubella < > Rash, mild swelling of neck glands, joint swelling or aching may occur 1-3 weeks after receiving vaccine. Usually no treatment is recommended. See your doctor if this is severe.

If there is a family history of convulsions in parents or brothers or sisters, consideration should be given to giving a non-aspirin fever medication five days after the vaccine is received and then every 4 to 6 hours for 5 to 7 days.

[ ] Hib (Meningitis) - Haemophilus influenzae b

< > Some children will get fever, redness, swelling or tenderness at the site of injection. Give extra fluids. Some children will have fever of 102.2° F or higher.

IMPORTANT:

- If there is fever over 101° F, follow your doctor's direction for fever medication.
- Relieve redness and tenderness at injection site by placing a cold washcloth on the area for 15 minutes every 2-3 hours.
- If swelling remains after 24 hours, use a warm washcloth on the area for 15 minutes every 2-3 hours.

IMMUNIZATION SCHEDULE

2 months	DTP, OPV, Hib
4 months	DTP, OPV, Hib
6 months	DTP, Hib
15 months	DTP, OPV, MMR, Hib
4-6 years	DTP, OPV
Every 10 years	Td

Schedule for Completion (date doses needed)

Vaccine	1st	2nd	3rd	4th	5th
DTP and/or DT/Td					
OPV/IPV					
MMR					
Hib					

If the receiver of the vaccine becomes ill and visits a doctor, hospital or clinic during the 4 weeks after immunization(s), please report it to your County Health Department at:

ADHS/DDP/IMM/107 (Rev. 3/91) *See reverse side for information on fever.

Temperatures on infants and young children are generally taken with a thermometer, placed under the arm or inserted in the rectum. Temperatures are taken by mouth (oral) only if the child is old enough to keep the thermometer under the tongue with the mouth closed to avoid biting and possibly breaking the thermometer. Ask your doctor or nurse to teach you how to use and read a thermometer.

Fevers are best treated by giving your child more liquids to drink (water, clear juices, such as apple; or soft drinks such as ginger ale, lemon/lime). Lukewarm tub baths or sponge bathing may also help bring the fever down. Fevers can also be treated with aspirin or non-aspirin products.

For fever prevention, a non-aspirin product such as Tylenol, Tempra, Liquiprin, etc. may be given. There are many non-aspirin (Acetaminophen) products available. Your decision to buy it in liquid or tablet form will depend on the age of your child. It is important that you carefully **read** the **instructions** included with the product to know how much you should give and **how often** it should be given. If you have questions ask your doctor or clinic.

A child with a fever lasting longer than 2 days or one which will not go lower than 101° F with treatment needs medical attention. Consult your doctor/or clinic.

Historical Note
Section R9-25-802, Exhibit 2 recodified from A.A.C. R9-13-1502, Exhibit 2 (Supp. 98-1).

Editor's Note: The following Exhibit was originally adopted under an exemption from the provisions of the Administrative Procedure Act which means that these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on these rules; and the Attorney General did not certify these rules.

Exhibit 3. Consent For Immunization

NAME: _____ _____ _____
Last First MI Birthdate Age

Mother's name:_____Child's SS # (if available):_____

ADDRESS:_____
City State Zip

PHONE:_____

I have been given a copy and have read or had explained to me the information contained in the Important Information Statements about the following disease(s) and vaccine(s): polio (live and killed), Diphtheria, Tenanus, Pertussis, Measles, Mumps, Rubella singly or in combination, Haemophilus Influenzae type b, and Hepatitis B. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on this form be given to me or the person named on this health record for whom I am authorized to make this request. I understand these pamphlets may go home with me.

	DOSE	SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE REQUEST	DATE
OPV			
Oral			
IPV			
(IM)			
DTP			
L arm/L leg (IM)			
DT			
L arm/L leg (IM)			
Td			
L arm (IM)			
Hib			
R arm/R leg (IM)			
MMR			
R arm/SO			
HBV			
R arm (IM)			
Tb Skin Test			

Adapted from the Maricopa County Public Health Services "Consent for Immunization"

RECALL 2 mo 6 mo 1 yr
3 OPV, 4 DTP, 1 Hib, 1 MMR ☐

Historical Note

Section R9-25-802, Exhibit 3 recodified from A.A.C. R9-13-1502, Exhibit 3 (Supp. 98-1).

Editor's Note: The following Exhibit was adopted under an exemption from the provisions of the Administrative Procedure Act which means that these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

Exhibit 4. Vaccine Administration

Vaccine	Dose	Route*	Site	Remarks Epinephrine (1:000 must be available at all times)
OPV Oral Polio	2 gtts.	Oral	Mouth	Back of tongue or buccal mucosa. Vaccine is clear and pink, to orange.
IPV Inactivated Polio	0.5 ml.	Subcutaneous	Deltoid	After insertion of needle, aspirate before injecting, to make certain no blood is withdrawn. Vaccine is clear, colorless.
DTP (Diphtheria, Pertussis, Tetanus) to age 7 DT (Diphtheria, Tetanus) to age 7 Td (tetanus, diphtheria) age 7 and older	0.5 ml. 0.5 ml. 0.5 ml.	Intramuscular Intramuscular Intramuscular	Infants: Non-walking, Vastus Lateralis (mid lateralthigh) anterolateral (Left) Children walking, Deltoid (left arm)	Shake well before withdrawing. After withdrawing vaccine into the syringe and before injecting take care not to let the preparation dribble down the needle. To keep a drop from forming at the needle tip, pull back on the syringe plunger slightly, so that a little air enters the needle (this causes no harm). These measures reduce the amount of vaccine that is tracked through subcutaneous tissue. Aspirate before injecting vaccine. Vaccine is cloudy white color.
Hib Haemophilus b Conjugate	0.5 ml.	Intramuscular	Vastus Lateralis deltoid (Right leg/arm)	Aspirate before injecting vaccine. Vaccine is clear and colorless.
HBV Hepatitis B	Per mfg. and age	Intramuscular	Vastus Lateralis deltoid (Right leg/arm)	Aspirate before injecting vaccine. Vaccine is clear and colorless.
M, MR, MMR Measles, Mumps, Rubella	0.5 ml.	Subcutaneous	Outer aspect of upper arm (right arm)	Use only diluent supplied for MMR products. Shake well before withdrawing. Aspirate before injecting vaccine. Vaccine is clear, straw color.

* Needle size for administration:
Subcutaneous: 5/8" 25 gauge
Intramuscular: 1" to 1 1/2" 21 to 23 gauge

* For simultaneous administration of HBV and Hib: use right vastus lateralis for both with one inch between sites.

Editor's Note: The remainder of Exhibit 4 was partially illegible and therefore is not reprinted here. Please contact the Department of Health Services for copies of this information.

Historical Note
Section R9-25-802, Exhibit 4 recodified from A.A.C. R9-13-1502, Exhibit 4 (Supp. 98-1).

The following Section was repealed and a new Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 36-2205 (C). Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register as proposed rules; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings on this Section (Supp. 98-4).

R9-25-803. Protocol for Drug Box Procedures

A. In addition to the definitions in R9-25-101, the following definitions apply in this protocol unless otherwise specified:

1. "Accredited health care institution" means the same as the definition in A.R.S. § 36-401.
2. "Accredited hospital" means the same as the definition in A.R.S. § 36-401.
3. "Agency" means the same as the definition in R9-25-101.
4. "Base hospital" means the same as the definition of "advanced life support base hospital" as defined in A.R.S. § 36-2201.
5. "Base hospital medical director" means a physician who meets the requirements in R9-25-207.
6. "Controlled substance" means the same as the definition in A.R.S. § 32-1901(12).
7. "Drug" means any of the medications in Exhibit 1 and Exhibit 2.
8. "Drug box" means a container to hold the drugs in Exhibit 1.
9. "Emergency receiving facility" means the same as the definition in A.R.S. § 36-2201.
10. "EMT-B" means a basic emergency medical technician and is the same as the definition in A.R.S. § 36-2201.
11. "Independent supplier" means an entity permitted by the State Board of Pharmacy pursuant to A.R.S. § 32-1929 to sell or stock drugs.
12. "Interfacility transport" means a prearranged ambulance transport of an individual receiving medical care from 1 licensed accredited hospital or licensed accredited health care institution to another licensed accredited hospital or licensed accredited health care institution.
13. "License" means the written authorization issued by the Department under A.R.S. Title 36, Chapter 4.
14. "Medical direction" means guidance provided by a physician for medical care of an individual through on-line medical direction, off-line medical direction, or standing orders.
15. "Monitor" means:
    a. To observe the administration rate of a drug and the response to the drug by the individual receiving the drug, or
    b. The ongoing responsibility to check the contents of a drug box as required in subsection (C)(4).
16. "Physician" means an individual licensed pursuant to A.R.S. §§ 32-1301 or 32-1701.
17. "Registered nurse" means an individual licensed pursuant to A.R.S. § 32-1601.

B. Only an individual authorized under R9-25-608(B) or a registered nurse may administer a drug under the medical direction of a medical direction authority.
1. When a controlled substance is ordered, an EMT-I, EMT-P, or registered nurse shall document the order on a first care form and a medical direction authority shall sign the form.
2. A copy of the first care form in subsection (B)(1) shall be delivered to the pharmacy of the base hospital or emergency receiving hospital within 72 hours after the order is issued.

C. A base hospital, emergency receiving facility, or independent supplier who elects to provide the drugs listed in Exhibit 1 to an agency shall establish a written agreement with the agency to document:
1. Written policies established by the base hospital, emergency receiving facility, or independent supplier addressing requirements for secured drug boxes, distribution of drugs, drug box record keeping, and reporting.
2. An agency's responsibility to provide a base hospital, an emergency receiving facility, or an independent supplier with drug boxes that:
    a. Are washable.
    b. Are capable of being locked.
    c. Are large enough to contain all of the drugs listed in Exhibit 1.
    d. Include a listing of the location and identification of drugs.
3. An agency's assurance that:
    a. A drug box is stored in a locked compartment which provides security and that restricts movement of the drug box while vehicle is in motion.
    b. Unauthorized individuals do not have access to a drug box.
    c. The contents of a drug box are maintained at temperatures recommended by the drug manufacturer.
    d. When a drug box is assigned to an EMT-I, EMT-P, or a registered nurse, the name of the EMT-I, EMT-P, or registered nurse, and the time and date of assignment are recorded in writing. An agency shall maintain the record for 30 calendar days from the date of entry.
4. An EMT-I, EMT-P, or a registered nurse shall:
    a. Monitor the contents of a drug box for expired drugs, deteriorated drugs, damaged drug containers or labels, altered drug containers or labels, or missing drugs. If any of these conditions occur, the EMT-I, EMT-P, or registered nurse shall notify the supervisor of the EMT-I, EMT-P or the registered nurse, the base hospital, the emergency receiving facility pharmacy, or the independent supplier and return the affected drugs to the base hospital, the emergency receiving facility's pharmacy, or the independent supplier.
    b. Verify the inventory of a drug box by conducting an inspection of the drug box before delivery to the next assigned EMT-I, EMT-P, or registered nurse. The verification shall be in writing and contain the name or EMT certification number of the EMT-I, EMT-P, or registered nurse conducting the inspection and date and time of inspection.
    c. Record each administration of a drug on the individual's first care form and follow the reporting requirements in R9-25-615.

D. Within 72 hours of the discovery of any conditions in subsection (C)(4)(a) for a controlled substance, a base hospital, an emergency receiving facility, or an independent supplier shall notify the Department by telephone or facsimile transmission specifying the date of discovery, type of controlled substance involved and type of exception. If the notification is by telephone, the base hospital, the emergency receiving facility or the independent supplier shall send to the Department by certified mail the information contained in this Section.

E. An agency shall exchange or resupply drugs only from a base hospital, an emergency receiving facility, or an independent supplier with which the agency has a current written agreement for resupplying drugs:
1. If an agency is obtaining drugs from a base hospital, an emergency receiving facility, or an independent supplier that mandates a drug box-for-box exchange, the agency shall obtain sufficient drug boxes to assure the agency's acquisition of a new drug box within 30 minutes of the return of a used drug box to the base hospital or the emergency receiving facility.
2. If an agency is obtaining drugs from a base hospital, an emergency receiving facility, or an independent supplier that allows drug-for-drug exchange, the agency shall ensure that an EMT-I, EMT-P, or a registered nurse docu-

ments the exchange on a form that includes the name of the drug exchanged and the date and time of exchange.

F. Except as provided in subsection (I), a base hospital's pharmacy, an emergency receiving facility, or an independent supplier shall provide the contents of a drug box in the supply ranges set forth in Exhibit 1.

G. Except for a controlled substance, a medical director of a base hospital may request permission to provide a drug in an amount that exceeds the supply range in Exhibit 1.

1. The medical director of a base hospital shall submit a request in writing to the Department that contains:
   a. The name of the agency for whom the exception is being requested,
   b. The name of the drug,
   c. The additional amount of the drug being requested,
   d. The reason for the request, and
   e. The signature of the medical director.
2. Within 15 working days after receipt of a request, the Department shall review the request and:
   a. Approve the request after determining that the request protects public health and safety based on such factors as the response area, response time, or location of supply;
   b. Deny the request after determining that the request fails to provide for protection of health and safety.

H. A certified emergency medical technician authorized by R9-25-508 or R9-25-608 shall receive approval of the base hospital medical director before interfacility transport of an individual receiving any drug listed in Exhibit 2. An EMT-I or EMT-P shall receive training in the administration of an Exhibit 2 drug before monitoring an IV infusion delivery during interfacility transport of an individual. Before an infusion pump is used for drug delivery, an EMT-I or EMT-P shall receive training in the administration of an Exhibit 2 drug and the use of the infusion pump that will be used to administer the Exhibit 2 drug.

Historical Note

Section R9-25-803 recodified from A.A.C. R9-13-1503, (Supp. 98-1). Section repealed; new Section adopted effective November 30, 1998; filed in the Office of the Secretary of State November 24, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) (Supp. 98-4).

The following Exhibit was repealed and a new Exhibit was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 36-2205 (C). Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register as proposed rules; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings on this Section (Supp. 98-4).

Exhibit 1. EMT-P Drug List; EMT-I Drug List

EMT-P DRUG LIST

AGENT	CONCENTRATION	STANDARD SUPPLY
ADENOSINE	6 mg/2 ml	5 - 6
ALBUTEROL SULFATE (SULFITE FREE)*	2.5 mg/3 ml NS	2 - 6
ASPIRIN, PEDIATRIC CHEWABLE	80 mg (INDEPENDENT DOSE)	4 - 8
ATROPINE	1 mg/10 ml	3 - 4
ATROPINE	8 mg/20 ml	1 - 2
BRETYLIUM	500 mg/10 ml	1 - 3
CALCIUM CHLORIDE	1 gm/10 ml	1 - 2
CHARCOAL, ACTIVATED**	25 gm	2 - 4
DEXTROSE	25 gm/50 ml	2 - 4
DIAZEPAM	10 mg/2ml	2
DIPHENHYDRAMINE	50 mg/1 ml	1 - 2
DOPAMINE HCL	400 mg/5 ml (PREMIX/D5W OPTIONAL)	1 - 2
EPINEPHRINE (1:1,000 SOL)	1 mg/1 ml (AMPULES OR PREFILLED SYRINGES)	1 - 2
	1 mg/ 1 ml multidose 30 ml vial	1 - 2
EPINEPHRINE (1:10,000 SOL)	1 mg/10 ml prefilled syringes	6 - 8
FUROSEMIDE	40 mg/4 ml	2 - 4
GLUCAGON	1 mg/1 ml	1 - 2
IPRATROPIUM BROMIDE 0.01%	2.5 ml	2 - 4
LIDOCAINE IV	100 mg/5 ml	3 - 4
LIDOCAINE IV	1 gm/25 ml	1 - 2
LIDOCAINE IV	2 gm/500 ml (PREMIX/D5W OPTIONAL)	1 - 2
MAGNESIUM SULFATE	1 gm/2ml	4 - 10
METHYLPREDNISOLONE	125 mg	1 - 2
MORPHINE SULFATE	10 mg/1 ml	2
NALOXONE	0.4 mg/1 ml	Total 10 mg
	1 mg/1 ml	
NITROGLYCERIN (NITROSTAT TABLETS)	0.4 mg tab/25 in bottle	1 - 2
OXYTOCIN	10 units/1 ml	1 - 2
PHENYLEPHRINE (NEO-SYNEPHRINE NASAL SPRAY)	0.5% 15 ml	1 - 2
SODIUM BICARBONATE	50 mEq/50 ml	2 - 3
THIAMINE	100 mg/1 ml	1 - 2
VERAPAMIL	5 mg/2 ml	2 - 3

NITROUS OXIDE (NITRONOX)	Nitrous Oxide 50%/Oxygen 50% fixed ratio with 02 fail safe device with self-administration mask. Optional)	
SYRINGES:	1 ml (TB 25 g)	2
	3 ml	4
	10 - 12 ml	4
	20 ml	2
	50-60 ml	2
FILTER NEEDLES	5 micron 19 g 1 1/2”	3
NON-FILTER NEEDLES		Assorted
INTRAVENOUS SOLUTIONS: (Bulk Restricts inclusion of all fluids in Drug Box)		
DEXTROSE, 5% in H20	250 ml bag	1
LACTATED RINGER’S OR NORMAL SALINE	1 L BAGS	8 L
NORMAL SALINE	250 ml bag	3
NORMAL SALINE	50 ml bag	2
SALINE 0.9% lock	1 ml fluid flush	2 - 5

*Administer by nebulizer
**May store in a drug box or compartment on an ambulance

EMT-I DRUG LIST

AGENT	CONCENTRATION	STANDARD SUPPLY
ALBUTEROL SULFATE (SULFITE FREE)*	2.5 mg/3 ml NS	2 - 6
ASPIRIN, PEDIATRIC CHEWABLE	80 mg (INDEPENDENT DOSE)	4 - 8
ATROPINE	8 mg/20 ml	1 - 2
CHARCOAL, ACTIVATED**	25 gm	2 - 4
DEXTROSE	25 gm/50 ml	2 - 4
DIAZEPAM	10 mg/2ml	2
DIPHENHYDRAMINE	50 mg/1 ml	1 - 2
EPINEPHRINE (1:1,000 SOL)	1 mg/1 ml (AMPULES OR PREFILLED SYRINGES)	1 - 2
	1 mg/ 1 ml multidose 30 ml vial	1 - 2
EPINEPHRINE (1:10,000 SOL)	1 mg/10 ml PREFILLED SYRINGES	3 - 6
FUROSEMIDE	40 mg/4 ml	2 - 4
GLUCAGON	1 mg/1 ml	1 - 2
IPRATROPIUM BROMIDE 0.01%	2.5 ml	2 - 4
METHYLPREDNISOLONE	125 mg	1 - 2
MORPHINE SULFATE	10 mg/1 ml	2
NALOXONE	0.4 mg/1 ml	TOTAL 10 mg
	1 mg/1 ml	
NITROGLYCERIN (NITROSTAT TABLETS)	0.4 mg tab/25 in bottle	1 - 2
OXYTOCIN	10 units/1 ml	1 - 2
PHENYLEPHRINE (NEO-SYNEPHRINE NASAL SPRAY)	0.5% 15 ml	1 - 2
SODIUM BICARBONATE	50 mEq/50 ml	2 - 3
THIAMINE	100 mg/1 ml	1 - 2
NITROUS OXIDE (NITRONOX)	Nitrous Oxide 50%/Oxygen 50% fixed ration with 02 fail safe device with self-administration mask. Optional	
SYRINGES:	1 ml (TB 25 g)	2
	5 ml	2
	10 ml	2
	20 ml	2
FILTER NEEDLES	5 micron 19 g 1 1/2”	3
NON-FILTER NEEDLES		Assorted
INTRAVENOUS SOLUTIONS: (Bulk restricts inclusion of all fluids in Drug Box)		
DEXTROSE, 5% in H20	250 ml bag	1
LACTATED RINGER’S/ OR NORMAL SALINE	1 L bags	8 L
NORMAL SALINE	250 ml bag	3
SALINE 0.9% lock	1 ml fluid flush	2 - 5

* Administer by nebulizer
** May store in a drug box or a compartment on an ambulance

Historical Note

Section R9-25-803, Exhibit 1 “EMT-P Drug List” and “EMT-I Drug List” recodified from A.A.C. R9-13-1503, Exhibit 1 “EMT-P Drug List” and “EMT-I Drug List” (Supp. 98-1). Exhibit 1 repealed; new Exhibit 1 adopted effective November 30, 1998; filed in the Office of the Secretary of State November 24, 1998, under an exemption from the provisions of the Administrative Procedure

Act pursuant to A.R.S. § 36-2205(C) (Supp. 98-4).

The following Exhibit was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 36-2205 (C). Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register as proposed rules; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings on this Exhibit (Supp. 98-4).

Exhibit 2. Intravenous Infusions to be Monitored by Appropriate Level of EMT Personnel

INTRAVENOUS INFUSIONS TO BE MONITORED BY APPROPRIATE LEVEL OF EMT PERSONNEL

IV INFUSIONS	EMT-B	EMT-I	EMT-P	INFUSION PUMP
AMINOPHYLLINE			X	X
ANTIBIOTICS		X	X	
ANTIARRHYTHMICS: PHENYTOIN			X	X
ANTIARRHYTHMICS: PROCAINAMIDE			X	X
BRETYLIUM			X	
BLOOD			X	
CALCIUM CHLORIDE			X	
COLLOIDS: DEXTRAN; HETASTARCH; HUMAN SERUM; ALBUMIN; MANNITOL; PLASMANATE		X	X	
CORTICOSTEROIDS		X	X	
CRYSTALLOIDS (> USUAL/CUSTOMARY)			X	
DIURETICS			X	
DOPAMINE			X	X
ELECTROLYTE ADDITIVES (>USUAL/CUSTOMARY)			X	
EPINEPHRINE			X	X
HEPARIN			X	X
ISOPROTERENOL			X	X
LIDOCAINE			X	X
MAGNESIUM			X	X
MORPHINE SULFATE		X	X	X
NITROGLYCERINE			X	X
OXYTOCIN		X	X	
PHENOBARBITAL			X	X
SODIUM BICARBONATE		X	X	
DRUG BOX SOLUTIONS AND AGENTS OF AUTHORIZED SKILL LEVELS		X	X	
VITAMINS		X	X	
WATER/ELECTROLYTES (COMMERCIAL PREPS)	X	X	X	

Historical Note

Exhibit 2 adopted effective November 30, 1998; filed in the Office of the Secretary of State November 24, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) (Supp. 98-4).

R9-25-804. Reserved

R9-25-805. Protocol for IV Access by EMT-Basics

A. IV access shall be performed only by an EMT-Basic who has received training in this optional procedure meeting the curriculum and course outline requirements as shown in Exhibit 1 and Exhibit 2.

B. Prior to performing IV access, an EMT-Basic trained in IV access shall have received prior written approval from the EMT-Basic's EMS provider agency and from an ALS base

hospital medical director who agrees to provide medical control authority for the EMT-Basic.

C. An EMT-Basic shall perform IV access only under "on line" medical direction, under standing orders approved by the ALS base hospital medical director, or under the direction of a currently certified EMT-paramedic or EMT-intermediate who is also attending the patient upon whom the EMT-Basic is to perform the procedure.

D. An EMT-Basic shall be trained to use this procedure in a manner which shall not delay patient transportation to the hospital.

E. The base hospital shall be responsible for quality assurance and skill maintenance, and shall record and maintain the EMT-Basic's IV access attempts on the QA form as shown in Exhibit 3. These forms shall be retained throughout an EMT-Basic's current certification period.

F. An EMT-Basic trained in this optional procedure shall have a minimum of 5 IV starts per year. If less than 5, the EMT-Basic shall participate in a supervised base hospital clinical experience in which to obtain the minimum of 5 IV starts.

G. In this Section, unless the context otherwise requires, "EMS provider agency" means the employer of a person certified as an EMT-Basic.

Historical Note

Adopted under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 36-2205 (C), effective May 19, 1997; filed in the Office of the Secretary of State May 21, 1997 (Supp. 97-2).

Exhibit 1. Lecture/Lab Vascular Access for EMT-Basics

Lecture/Lab

Vascular Access for EMT-Basics

Course Description:

Includes review of anatomy of the circulatory system. Skills will include peripheral intravenous cannulation techniques, fluid resuscitation, obtaining venous blood samples for laboratory analysis; infection control techniques for the safety of self and victim; complications of intravenous cannulation.

Prerequisites:

Certified EMT-Basic, under Medical Direction

Credit Hours:

One (1) credit hour; 16-clock hours

Course Competencies:

This course is designed to develop the following course competencies:

1. Identify the need for fluid resuscitation in neonate, infant, pediatric, and adult victims (I);
2. Identify and describe the vascular anatomy and venous access for the neonate, infant, pediatric, and adult victims (II);
3. Identify and differentiate isotonic, hypotonic, and hypertonic solutions (III);
4. Select fluids; set up and manage equipment (IV);
5. Identify and demonstrate aseptic and safety techniques (V);
6. Identify and describe indications and contraindications for intravenous site selection (VI);
7. Perform all peripheral intravenous cannulation techniques (VII);
8. Perform blood drawing techniques (VIII);
9. Monitor infusion (IX);
10. Demonstrate 100% accuracy in intravenous techniques in selected scenarios (X);
11. Demonstrate 85% proficiency on a written examination (XI).

Historical Note

Adopted under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 36-2205 (C), effective May 19, 1997; filed in the Office of the Secretary of State May 21, 1997 (Supp. 97-2).

Exhibit 2. Course Outline

Vascular Access for EMT-Basic

COURSE OUTLINE

I. Indications for Vascular Access
   - A. Restore fluid volume
   - B. Restore and maintain electrolyte balance
   - C. Administration of medications
   - D. Obtaining blood specimen

II. Identification of common vascular sites

III. Intravenous Solutions
   - A. Isotonic
   - B. Hypotonic
   - C. Hypertonic
   - D. Indications for each

IV. Needle/Catheters and Intravenous Administration Sets
   - A. Types

B. Sizes
C. Administration sets
1. pediatric
2. blood pump
3. 3-way
4. pressure infuser
D. Set-up

V. Asepsis and Safety
A. Site preparation
B. Universal precautions
C. "Sharp" disposal

VI. Site selection

VII. Peripheral Intravenous Cannulation

VIII. Drawing Blood
A. Indication
B. Site preparation
C. Universal precautions
D. Identification of specimen(s)
E. "Sharp" disposal
F. Documentation

XI. Monitoring the Intravenous Infusion
A. Signs and symptoms of infiltration and extravasation
B. Techniques for removal
C. Documentation

X. Practicals
A. Mannequin
B. Human subjects

XI. Final Written Examinations

Historical Note
Adopted under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 36-2205 (C), effective May 19, 1997; filed in the Office of the Secretary of State May 21, 1997 (Supp. 97-2).

Exhibit 3. IV QA Form

EMT-Basic IV Access QA Form:

Standing orders: _____ Paramedic/IEMT direction: _____

Incident # _____ Date_____

Ambulance on scene time: _____

EMT # _____ Name _____

ALS on scene time: _____

Patient Age: _____ Sex: M F

ALS meds given IV: Yes _____ No _____ Time given: _____

BLS on scene time: _____

EMT IV attempts: ____ If greater than 2, give reason: _____

IV start time: _____ IV on scene_____ IV enroute _____

Complications: Yes _____ No _____ Describe _____

Type of fluid: _____ Volume infused: _____

Medical Control Authorization: On-line base hospital:_____

Patient Outcome: _____

Historical Note
Adopted under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 36-2205 (C), effective May 19, 1997; filed in the Office of the Secretary of State May 21, 1997 (Supp. 97-2).

TITLE 9. HEALTH SERVICES

CHAPTER 26. COUNCIL FOR THE HEARING IMPAIRED

(Authority: A.R.S. §§ 36-1946 and 36-1947 et. seq)

ARTICLE 1. GENERAL

Section
R9-26-101. Definitions

ARTICLE 2. ELIGIBILITY AND REGISTRATION

Section
R9-26-201. Eligibility requirements
R9-26-202. Approval of an application
R9-26-203. Denial of eligibility
R9-26-204. Notice
R9-26-205. Review by the Director
R9-26-206. Hearing by the Council
R9-26-207. Rehearing or review of decision

ARTICLE 3. DISTRIBUTION PROCESS

Section
R9-26-301. Original distribution
R9-26-302. Training
R9-26-303. Replacement devices
R9-26-304. Ownership and liability
R9-26-305. Out-of-state use

ARTICLE 4. RELAY SERVICES

Section
R9-26-401. Telephone relay centers
R9-26-402. Confidentiality and privacy requirements
R9-26-403. Criminal activity

ARTICLE 5. INTERPRETER CERTIFICATION

(Authority: A.R.S. § 36-1946 (A))

Article 5, consisting of Sections R9-26-501 through R9-26-511, adopted effective April 4, 1997 (Supp. 97-2).

Section
R9-26-501. Definitions
R9-26-502. Process for Obtaining Interpreters
R9-26-503. Sign Language Interpreter Certification
R9-26-504. Temporary Sign Language Interpreter Certification
R9-26-505. Grandfathering Sign Language Interpreters
R9-26-506. Oral Interpreter Certification
R9-26-507. Realtime Reporter Certification
R9-26-508. Application Processing Procedures; Issuance; Denial
R9-26-509. Certification Renewal
R9-26-510. Certification Revocation
R9-26-511. Rehearing or Review of Decisions

ARTICLE 1. GENERAL

R9-26-101. Definitions

The following definitions shall apply in this Chapter, unless the context otherwise requires:

1. "Applicant" means a person who applies for a Telecommunication Device for the Deaf (hereinafter "TDD") or signal device.
2. "Audiologist" means a person who has a Master's or Doctoral degree in audiology and a Certificate of Clinical Competence in audiology from the American Speech/Language/Hearing Association.
3. "Council" means the Arizona Council for the Hearing Impaired.
4. "Deaf" means a hearing loss that requires use of a TDD to communicate effectively on the telephone.
5. "Deaf-blind" means a hearing loss and a visual impairment that require use of a TDD to communicate effectively on the telephone.
6. "Director" means the Executive Secretary of the Arizona Council for the Hearing Impaired.
7. "Distribution center" means a facility authorized by the Council to distribute TDDs and signal devices.
8. "Hearing aid dispenser" means a person who is licensed by the Arizona Department of Health Services to fit and dispense hearing aids and who is certified in Hearing Instruments Sciences by the National Board for Certification in Hearing Instruments Sciences.
9. "Out of area" means any location more than (50) fifty miles from a Distribution Center.
10. "Recipient" means a person who receives a TDD or a signal device.
11. "Speech/language pathologist" means a person who has a Master's degree or equivalency in Speech/Language Pathology and a Certificate of Clinical Competence issued by the American Speech/Language/Hearing Association.
12. "Severely hearing impaired" means a hearing loss that requires use of a TDD to communicate effectively on the telephone.
13. "Severely speech impaired" means a speech impediment that renders speech on an ordinary telephone unintelligible.
14. "Signal device" means a mechanical device that alerts a deaf, deaf-blind, or severely hearing impaired person of an incoming telephone call.
15. "Telecommunication device for the deaf" means an electrical device for use with a telephone that utilizes a key board, acoustic coupler, display screen or braille display to transmit and receive messages.
16. "Telephone relay center" means a facility authorized by the Council to provide telephone relay service.
17. "Telephone relay service" means the provision of voice and teletype communication between users of TDDs and other parties.

Historical Note

Adopted effective May 12, 1986 (Supp. 86-3).

ARTICLE 2. ELIGIBILITY AND REGISTRATION

R9-26-201. Eligibility requirements

A. An applicant is eligible only if he is deaf, deaf-blind, severely hearing impaired or severely speech impaired. Such impairment must be established by certification on an application form by a person who is permitted to practice medicine in the state of Arizona, an audiologist, speech pathologist or hearing aid dispenser.

B. The Director may require additional documentation to determine if the applicant meets the foregoing eligibility requirements.

C. During the training session as required by R9-26-302, applicant must demonstrate an ability to send and receive messages with a TDD.

Historical Note

Adopted effective May 12, 1986 (Supp. 86-3).

R9-26-202. Approval of an application

If an applicant is determined to be eligible, the Director shall approve the application except as stated in R9-26-203.

Historical Note

Adopted effective May 12, 1986 (Supp. 86-3).

R9-26-203. Denial of eligibility

A. Original application. The Director shall deny an original application for a TDD if:
1. Applicant does not meet the eligibility requirements of R9-26-201; or
2. Applicant has already been issued a TDD.

B. Replacement request. The Director shall deny a replacement request for a TDD or signal device if:
1. A device issued has been subjected to abuse, misuse or unauthorized repair by a recipient; or
2. The recipient fails to provide a police report of a stolen device; or
3. The recipient has lost the device.

Historical Note

Adopted effective May 12, 1986 (Supp. 86-3).

R9-26-204. Notice

A. Approved applications
1. When an original application has been approved, the Director shall inform the applicant in writing of:
   a. The location of the Distribution Center or Out of Area address where applicant may receive a TDD.
   b. The date and time of the training session as required by R9-26-302.
2. When the request for a replacement TDD or signal device has been approved, the Director or the Distribution Center shall inform the recipient of the procedure for obtaining a replacement device.

B. Denied applications. If an original application or replacement request is denied, the Director shall inform the applicant in writing of the reasons for the denial and of any applicable procedures for appeal. All denial notices shall be sent Certified Mail with Return Receipt.

Historical Note

Adopted effective May 12, 1986 (Supp. 86-3).

R9-26-205. Review by the Director

A. An applicant or recipient whose request for an original or replacement TDD has been denied may request that the Director review the decision.

B. The request for review shall be in writing and shall specify the basis for review and must be received by the Director within thirty (30) days of the receipt of the notice of denial.

C. Within ten (10) days of receiving the request for review, the Director shall inform the applicant or recipient in writing of the disposition of the request.

Historical Note

Adopted effective May 12, 1986 (Supp. 86-3).

R9-26-206. Hearing by the Council

A. Within ten (10) days of a notice of denial from the Director, the applicant or recipient may request in writing a hearing by the Council. The request shall specify the reasons for challenging the Director's decision.

B. The Council shall hold a hearing within ninety (90) days of receipt of the request.

Historical Note

Adopted effective May 12, 1986 (Supp. 86-3).

R9-26-207. Rehearing or review of decision

A. Except as provided in subsection (G), any party in a contested case before the Council who is aggrieved by a decision rendered in such case may file with the Council, not later than ten (10) days after service of the Council's decision, a written motion for rehearing or review of the decision specifying the particular grounds therefor. For purposes of this subsection, a decision shall be deemed to have been served when personally delivered or mailed by certified mail to the party at his last known residence or place of business.

B. A motion for rehearing under this rule may be amended at any time before it is ruled upon by the Council. A response may be filed by any other party within ten (10) days after service of such motion or amended motion. The Council may require the filing of written briefs upon the issues raised in the motion and may provide for oral argument.

C. A rehearing or review of the decision may be granted for any of the following causes materially affecting the moving party's rights:
1. Irregularity in the administrative proceedings of the agency or its hearing officer or the prevailing party, or any order or abuse of discretion, whereby the moving party was deprived of a fair hearing;
2. Misconduct of the Council or its hearing officer or the prevailing party;
3. Accident or surprise which could not have been prevented by ordinary prudence;
4. Newly discovered material evidence which could not with reasonable diligence have been discovered and produced at the original hearing;
5. Error in the admission or rejection of evidence or other errors of law occurring at the administrative hearing;
6. That the decision is not justified by the evidence or is contrary to law.

D. The Council may affirm or modify the decision or grant a rehearing to all or any of the parties and on all or part of the issues for any of the reasons set forth in subsection (C). An order granting a rehearing shall specify with particularity the ground or grounds on which the rehearing is granted, and the rehearing shall cover only those matters so specified.

E. Not later than ten (10) days after a decision is rendered, the Council may on its own initiative order a rehearing or review of its decision for any reason for which it might have granted a rehearing on motion of a party. After giving the parties or their counsel notice and an opportunity to be heard on the matter, the Council may grant a motion for rehearing for a reason not stated in the motion. In either case the order granting rehearing shall specify the grounds therefor.

F. When a motion for rehearing is based upon affidavits, they shall be served with the motion. Within ten (10) days of such service, an opposing party may serve opposing affidavits. This period may be extended by the Council for good cause shown or by written stipulation of the parties for an additional period not to exceed twenty (20) days. Reply affidavits may be permitted.

G. If in a particular decision the Council makes specific findings that the immediate effectiveness of such decision is necessary for the immediate preservation of the public peace, health and safety and that a rehearing or review of the decision is impracticable, unnecessary or contrary to the public interest, the decision may be issued as a final decision without an opportunity for a rehearing or review. If a decision is issued as a final decision without an opportunity for rehearing, any application for judicial review of the decision shall be made within the time limits permitted for applications for judicial review of the Council's final decisions.

Historical Note
Adopted effective May 12, 1986 (Supp. 86-3).

ARTICLE 3. DISTRIBUTION PROCESS

R9-26-301. Original distribution

A. Distribution centers shall:
1. Upon notice from the Director, distribute TDDs or signal devices to persons determined to be eligible under R9-26-201 who reside within fifty (50) miles of the distribution center.
2. Require all recipients or a legal guardian to sign a Conditions of Acceptance form supplied by the Council (incorporated herein by reference and on file in the Office of the Secretary of State).
3. Forward completed application forms and Conditions of Acceptance forms to the Director.
4. Inform the Director of those applicants who failed to report for training and receipt of devices.

B. The Director shall implement a program to facilitate distribution of TDDs and provide training as required for Out of Area locales.

C. Neither the distribution center nor the Director shall provide replacement paper for TDDs, the payment of the recipient's monthly telephone bill, purchase or lease costs of recipient's telephone or the cost of replacement light bulbs for signal devices.

Historical Note
Adopted effective May 12, 1986 (Supp. 86-3).

R9-26-302. Training

A. The distribution centers shall provide training to all recipients or legal guardians in accordance with guidelines established by the Council.

B. No applicant shall be issued a device until the applicant completes required training.

Historical Note
Adopted effective May 12, 1986 (Supp. 86-3).

R9-26-303. Replacement devices

Distribution centers shall issue devices to persons determined by the Director to be eligible under R9-26-201, accept devices that need repair, and deliver devices returned by recipients to repair centers designated by the Council.

Historical Note
Adopted effective May 12, 1986 (Supp. 86-3).

R9-26-304. Ownership and liability

A. All TDDs and signal devices are the property of the state of Arizona.

B. A recipient or guardian shall return a TDD and signal device to the Director or appropriate distribution center when the recipient no longer intends to reside in Arizona, does not need the devices, or has been notified by the Director to return the devices.

C. Recipients are liable for any damage to or loss of a device issued under R9-26-301.

Historical Note
Adopted effective May 12, 1986 (Supp. 86-3).

R9-26-305. Out-of-state use

A. No person shall remove a TDD or signal device from the state of Arizona for a period longer than ninety (90) days without the written permission of the Director.

B. The Director may grant permission to remove a TDD or signal device from the state of Arizona for more than ninety (90) days if the Director determines it is in the best interest of the recipient.

Historical Note
Adopted effective May 12, 1986 (Supp. 86-3).

ARTICLE 4. RELAY SERVICES

R9-26-401. Telephone relay centers

A. Telephone Relay Centers shall provide telephone relay services seven (7) days a week, twenty-four (24) hours a day, including holidays.

B. Telephone Relay Center shall hire operators who shall be salaried employees and not volunteers.

C. Telephone Relay Centers shall require all operators to relay all messages accurately, except as otherwise specifically provided in R9-26-403.

Historical Note
Adopted effective May 12, 1986 (Supp. 86-3).

R9-26-402. Confidentiality and privacy requirements

A. Except as otherwise specifically provided in R9-26-403, Telephone Relay Centers shall protect the privacy of persons to whom relay services are provided and shall require all operators to maintain the confidentiality of all telephone messages.

B. The confidentiality and privacy of persons to whom relay services are provided will be protected by means of the following:
1. Relay Centers shall not maintain any form of permanent copies of messages relayed by their operators or allow the content of telephone messages to be communicated to, or accessible to, non-staff members.
2. Persons using the relay services shall not be required to provide any identifying information until the party they are calling is on the line and shall only be required to identify themselves to the extent necessary to fulfill the purpose of their call.
3. Relay operators shall not leave messages with third parties unless instructed to do so by the person making the call.
4. Persons using the relay services may file complaints about the relay service to the Telephone Relay Center or the Council. All complaints will be reviewed by the Director.

Historical Note
Adopted effective May 12, 1986 (Supp. 86-3).

R9-26-403. Criminal activity

A. Relay operators shall not knowingly transmit telephone messages that are made in furtherance of any criminal activity as defined by Arizona or federal law.

B. The confidentiality and privacy requirements of R9-26-402 do not apply to telephone conversations made in furtherance of any criminal activity as defined by Arizona or federal law.

Historical Note
Adopted effective May 12, 1986 (Supp. 86-3).

ARTICLE 5. INTERPRETER CERTIFICATION

R9-26-501. Definitions

The following definitions apply in this Article:
1. "Applicant" means an individual who submits a completed application, and documentation to the Council to obtain a certificate of competency.
2. "Application" means a form provided to applicants by the Council, requiring the following information:

a. A photograph, measuring not less than 1 inch by 1 inch, of the applicant that was taken within 5 years of the date of filing the application;
b. The applicant's full current name and any former names;
c. The applicant's current address and telephone number;
d. The applicant's social security number;
e. Whether the applicant previously has applied for a certificate of competency;
f. The applicant's notarized signature, attesting to the truthfulness of the information provided by the applicant; and
g. The documentation required by this Article.

3. "ASL" means American Sign Language, the visual language used by deaf persons in the United States to communicate.
4. "CDI" means a certified deaf interpreter certificate, a certification issued by RID, evidencing that the certificate holder is deaf or hard-of-hearing, and performs at or above RID standards for deaf interpreters, but provides interpretation services with a hearing qualified interpreter.
5. "Certificate of competency" means a certificate issued by the Council indicating that the certificate holder has met the criteria set forth in this Article for the provision of interpretation services to deaf persons in court proceedings, government entity proceedings, and law enforcement encounters.
6. "Certification" means a currently valid card issued by RID, with the word "certified", and the categories in which the cardholder is certified, listed under the cardholder's name.
7. "Certified copy" means having a copy of the original document notarized as being a true and accurate copy of the original.
8. "CI" means certificate of interpretation, issued by RID, evidencing that the certificate holder performs at or above RID standards for sign language interpreters who interpret between ASL and English in both sign-to-voice and voice-to-sign.
9. "Continuing legal education" means seminars sponsored by a bar association, law firm, law department, or government entity, at which attendance is not limited to members of the association, firm, department, or entity, and that constitute an organized program of learning, dealing with matters directly related to the practice of law, and following an agenda defined by written materials or exercises distributed as part of the program.
10. "Council" means the Council for the Hearing Impaired.
11. "Court" means a place where people are officially assembled for the administration of justice, including all proceedings before every Grand Jury, Municipal Court, Justice Court, Magistrate Court, Superior Court, Court of Appeals, and Supreme Court in Arizona.
12. "CRR" means a certified realtime reporter certification issued by the NCRA, reflecting that the certificate holder has the training, experience, skills, and equipment to provide realtime on-screen translation, with at least 96% accuracy, for a deaf person in a proceeding.
13. "CSC" means a comprehensive skills certificate issued by RID, evidencing that the certificate holder performs at or above RID standards for sign language interpreters who interpret between ASL and English, and convert spoken English to an English-based sign system, in both sign-to-voice and voice-to-sign.
14. "CT" means a certificate of transliteration issued by RID and evidencing that the certificate holder performs at or above RID standards for sign language interpreters who convert spoken or written English to an English-based sign system, in both sign-to-voice and voice-to-sign.
15. "Custody" means that a person in a law enforcement encounter is not free to leave.
16. "Deaf person" means a person who is unable to fully process linguistic information through hearing, including any person who has an average pure tone decibel loss greater than 20dB in the better ear, any person who is observed by a court, government entity, or law enforcement personnel, without an interpreter, to need communication assistance to effectively participate in the proceeding, or any person who is hard-of-hearing, regardless of whether they wear hearing aids.
17. "English-based sign system" means using conceptually accurate American signs in English syntax. This is distinguishable from finger spelling using the alphabet, and from ASL, which also uses Americans signs, but not necessarily in conceptually accurate English syntax.
18. "Executive Secretary" means the executive officer of the Council who is responsible for implementing the Council's programs and activities, under A.R.S. § 36-1942.
19. "Government entity" means any department, board, commission, agency, or licensing authority of Arizona, or a political subdivision of Arizona.
20. "Intermediary interpreter" means a person holding a CDI certificate, an RSC certificate, or any person that a deaf person chooses to assist with interpretation services between the deaf person and a qualified interpreter.
21. "Law enforcement encounter" means any situation where a deaf person is questioned, arrested, or taken into custody for any alleged violation of Arizona criminal law, by any law enforcement personnel.
22. "NCRA" means the National Court Reporters Association.
23. "OIC" means an oral interpretation certificate issued by RID, evidencing that the certificate holder performs at or above RID standards for oral interpreters.
24. "Oral Interpreter" means a person who mouths a spoken message so that a deaf person can accurately speech read and understand the intent of the spoken message, and who accurately verbalizes the message and intent of the deaf person's speech and mouth movements.
25. "Party" means a deaf person who is a parent of a juvenile, a witness, complainant, defendant, or attorney in a court proceeding; a deaf person who is a principal party of interest, or a witness in a government entity proceeding; or a deaf person who is a defendant, or a criminal suspect in a law enforcement encounter.
26. "Proceeding" means any civil, criminal, or grand jury proceeding; any government entity proceeding; or any law enforcement encounter.
27. "Qualified interpreter" means a person who has a certificate of competency issued by the Council, and who is a court reporter who provides realtime translation, a sign language interpreter, or an oral interpreter.
28. "Realtime translation" means a court reporter's computer-aided method of accurately and simultaneously translating and displaying spoken words, including punctuation, in live proceedings, within 5 seconds of steno type input, for a deaf person to read.
29. "RID" means Registry of Interpreters for the Deaf.
30. "RSC" means a reverse skills certificate, which is the prior name of a CDI, and is synonymous with CDI.

31. "SC:L" means specialist certificate: legal issued by RID, evidencing that the certificate holder has specialized knowledge of the legal system, and performs at or above RID standards for interpreting in proceedings.
32. "Sign language interpreter" means a person who has a: (1) CI and CT; (2) CSC; (3) CDI; (4) RSC; or (5) SC:L certification from RID.
33. "Speech read" means determining what a person is saying by the person's mouth movements, body language, and the context of the conversation.
34. "Supervision" means that the supervising qualified interpreter has direct, in person contact with the interpreter that he or she is supervising, and provides orientation information to the supervisee about providing interpreter services in proceedings, observes the supervisee providing interpretation services in proceedings, has the supervisee observe the supervisor providing interpretation services in proceedings, and provides feedback to the supervisee about the supervisee's performance.

Historical Note
Adopted effective April 4, 1997 (Supp. 97-2).

R9-26-502. Process for Obtaining Interpreters

A. The court, government entity, or law enforcement personnel responsible for obtaining a qualified interpreter in any proceeding where a deaf person is a party, shall follow the steps stated in subsection (B).

B. The court, government entity, or law enforcement personnel shall:
1. Determine whether a party is a deaf person, either based on the party's request, or on the observation of the court, governmental entity, or law enforcement personnel;
2. Once a party is determined to be deaf, determine from the deaf person whether the deaf person needs sign language interpretation, oral interpretation, court reporter realtime translation, or a combination of interpretation services;
3. Determine, for sign language interpretation services, whether the deaf person needs ASL or an English-based sign system;
4. Arrange for a qualified interpreter to provide interpretation services; and
5. Determine from the deaf person whether the qualified interpreter meets the deaf person's communication needs at the outset of the proceeding or encounter, either upon complaint by the deaf person, or by observation of the court, government entity, or law enforcement personnel.

C. The deaf person may object to the qualified interpreter because the interpreter cannot meet the deaf person's communication needs. The court, government entity, or law enforcement personnel shall then appoint either an intermediary interpreter to work with the qualified interpreter or may provide another qualified interpreter that can meet the deaf person's communication needs.

Historical Note
Adopted effective April 4, 1997 (Supp. 97-2).

R9-26-503. Sign Language Interpreter Certification

A. The Council may issue a certificate of competency to an applicant who files an application with the Council, and submits all of the following:
1. A certified copy of the applicant's sign language interpreter RID certification;
2. An affidavit signed by the applicant, and notarized, attesting whether the applicant:
   a. Is a CI and CT, CSC, or SC:L certificate holder and has at least 2,000 hours of sign language interpreting experience within the 5 years immediately preceding the date of filing the affidavit with the Council, or is a CDI or RSC certificate holder and has at least 50 hours of sign language interpreting experience within the 5 years immediately preceding the date of filing the affidavit with the Council;
   b. Has ever been disciplined, or is currently the subject of any disciplinary action, in any jurisdiction or before RID relating to providing interpreting services or adhering to the RID Code of Ethics, set forth in subsection (C);
   c. Has ever been named, or is currently named, as a defendant in any law suit alleging the applicant was negligent in providing the applicant's interpreter services or alleging that the applicant violated the RID Code of Ethics, set forth in subsection (C);
   d. Follows the RID Code of Ethics, set forth in subsection (C), including the obligation to be absolutely neutral in all proceedings;
   e. Understands that the applicant shall ensure that the applicant's interpreting skills meet the deaf person's communication needs, and that failure to do so may be grounds for revocation of the applicant's certificate of competency;
   f. Understands that the applicant shall complete the continuing education requirements necessary to maintain current RID certification in the category or categories in which the Council issued the applicant's certificate of competency;
   g. Understands that the applicant shall complete at least 3 clock hours of continuing legal education every year in addition to RID continuing education requirements, shall maintain accurate records of compliance with this subsection, and shall produce the records upon the Council's request; and
   h. Understands that the applicant shall obtain RID SC:L certification by January 1, 2005.
3. Documentation that the applicant has provided at least 20 hours of sign language interpretation services to a deaf person under the supervision of a qualified interpreter in proceedings.

B. After January 1, 2005, a RID SC:L certification shall be the only RID certification that shall satisfy subsection (A)(1).

C. Interpreters shall comply with the following RID Code of Ethics requirements:
1. Keep all interpreting assignment related information confidential;
2. Render the message to accurately convey the content and spirit of the speaker, using language that the deaf person readily understands;
3. Not counsel, advise, or interject personal opinions;
4. Accept assignments using discretion with regard to their skills, the setting, and the deaf person involved;
5. Request compensation for services in a professional and judicious manner;
6. Maintain high professional standards in providing services, including maintaining absolute neutrality in all proceedings; and
7. Further their knowledge and skills by participating in workshops, professional meetings, interacting with professional colleagues, and reading current literature.

Historical Note
Adopted effective April 4, 1997 (Supp. 97-2).

R9-26-504. Temporary Sign Language Interpreter Certification

A. The Council may issue a temporary sign language interpreter certificate of competency to an applicant, who holds a CI and CT, CSC, or CDI RID certification, to provide interpretation services in proceedings under the supervision of a qualified interpreter for 1 year. This applicant shall file an application with the Council, and submit the following:
1. A certified copy of the applicant's CI and CT, CSC, or CDI RID certification; and
2. The names and addresses of the applicant's qualified interpreter supervisors.

B. The temporary certificate of competency shall automatically expire 1 year after the date of issue. The temporary certificate holder shall provide 20 hours of sign language interpretation services during the year that the temporary certificate is valid. If the 20 hours are not obtained before the temporary certificate expires, the applicant shall apply for another temporary certificate.

C. Beginning January 1, 2005, the Council shall no longer issue temporary certificates of competency.

Historical Note
Adopted effective April 4, 1997 (Supp. 97-2).

R9-26-505. Grandfathering Sign Language Interpreters

For up to 1 year after the effective date of these rules, the Council may issue a certificate of competency to an applicant who is a sign language interpreter, files an application with the Council, and submits the following:
1. The information required in R9-26-503(A)(1) and (2)(b) through (h); and
2. Documentation that the applicant has provided at least 20 hours of sign language interpretation services in proceedings before January 1, 1997.

Historical Note
Adopted effective April 4, 1997 (Supp. 97-2).

R9-26-506. Oral Interpreter Certification

A. The Council may issue an oral interpreter certificate of competency to an applicant who files an application with the Council, and submits the following:
1. A certified copy of the applicant's RID OIC certification, or documentation indicating that the applicant has provided at least 360 hours of oral interpreter services within the 3 years immediately preceding the date the applicant filed the documentation with the Council;
2. The information required in R9-26-503(A)(2)(b), (c), (d), (e), (f), and (g); and
3. A statement on the applicant's affidavit that the applicant understands that the applicant shall obtain RID OIC certification by January 1, 2005, if not already obtained, and shall complete the continuing education requirements necessary to maintain current RID certification.

B. After January 1, 2005, applicants for oral interpreter certificates of competency shall have an RID OIC certification to satisfy subsection (A)(1).

Historical Note
Adopted effective April 4, 1997 (Supp. 97-2).

R9-26-507. Realtime Reporter Certification

A. The Council may issue a realtime reporter certificate of competency to an applicant who files an application with the Council, and submits the following:
1. A certified copy of the applicant's Superior Court certification issued pursuant to A.R.S. § 12-222, and a notarized affidavit, signed by the applicant, attesting that the applicant has provided realtime translation in at least 2 trials in state or federal court; or
2. A certified copy of the applicant's NCRA Registered Professional Reporter, Registered Merit Reporter, or Registered Diplomate Reporter certification, and a notarized affidavit, signed by the applicant, attesting that the applicant has provided realtime translation in at least 2 trials in state or federal court; or
3. A certified copy of the applicant's CRR, and a notarized affidavit, signed by the applicant, attesting that the applicant follows the NCRA ethical requirements, set forth in subsection (C); and
4. A statement on the applicant's affidavit that the applicant understands that the applicant shall obtain NCRA CRR certification by January 1, 2005, if not already obtained, and shall complete the continuing education requirements necessary to maintain current NCRA CRR certification.

B. After January 1, 2005, NCRA CRR certification shall be the only certification that shall satisfy subsection (A).

C. Realtime translators shall comply with the following NCRA Code of Professional Ethics, Section II: Realtime Reporter as Assistive Technology in Legal Proceeding requirements:
1. Explain, before beginning realtime reporting, who has hired the reporter, what is to be reported, and that the realtime is to be used as assistive technology, not as a verbatim record of the proceeding;
2. Determine, before beginning realtime reporting, who owns the residual computer file;
3. Keep all assistive, assignment-related information confidential;
4. Render as near a verbatim translation as possible, conveying the content and spirit of the speaker, using substitute language that is computer-translatable for the deaf person to understand, and using parentheticals to describe to the deaf person all sounds during the proceeding;
5. Maintain absolute neutrality in all proceedings, by not counseling, advising, or interjecting personal opinions;
6. Accept assignments using discretion with regard to their skills, the setting, the deaf person being assisted, and accurately assessing the reporter's qualifications for realtime translation;
7. Know how to operate the software and hardware being used, including being able to troubleshoot anticipated problems that occur with software and hardware;
8. Further their knowledge and skills by participating in workshops, professional meetings, interaction with professional colleagues, reading current literature, and achieving additional state or national realtime certifications; and
9. Save a hard copy or computer disk of the actual translation that the deaf person saw on screen. If the translation is saved on computer disk, it shall be in text, or American standard code for information interchange format.
10. In addition to the ethical requirements in subsections (C)(1) through (9), realtime reporters shall not simultaneously act in a dual capacity as a realtime reporter for the benefit of a deaf person, and the stenographer who is recording the official verbatim record of the proceeding.

Historical Note
Adopted effective April 4, 1997 (Supp. 97-2).

R9-26-508. Application Processing Procedures; Issuance; Denial

A. Within 15 calendar days of receiving an initial or renewal certificate of competency application of any type, the Council shall notify the applicant, in writing, that the application pack-

age is complete or incomplete. If the package is incomplete, the notice shall specify what information is missing.

B. An applicant with an incomplete package shall supply the missing information within 10 calendar days from the date of the notice. If the applicant fails to do so, the Council may close the file. An applicant whose file has been closed shall begin the application process anew.

C. Upon receipt of all missing information within 10 calendar days, the Council shall notify the applicant, in writing, that the application is complete.

D. The Council shall not process a certificate of competency application until the applicant has fully complied with the requirements of this Article.

E. The Council shall notify an applicant, in writing, whether the certificate of competency is granted or denied, no later than 30 calendar days after the postmark date of the notice advising the applicant that the package is complete.

F. The Council may deny a certificate of competency for any of the following reasons:
1. Failure to provide complete documentation,
2. Providing false or misleading information, or
3. Failure to meet the requirements stated in this Article.

G. The notice of denial shall include the following:
1. Reasons for the denial, with citations to the statutes or rules on which the denial is based;
2. The applicant's right to request reconsideration pursuant to subsection (H); and
3. The name and telephone number of an agency contact person who can answer questions regarding the application process.

H. The following time frames shall apply for initial and renewal certificate of competency applications:
1. Administrative completeness review time frame: 15 calendar days.
2. Substantive review time frame: 30 calendar days:
3. Overall time frame: 45 calendar days.

I. Within 15 calendar days of the mailing date of the Council's notice of denial, the applicant may submit a request for reconsideration to the Council, setting forth the facts that justify reconsideration of the denial. The Council shall review all documentation, and interview any persons with information relevant to issuing or denying the applicant's certificate.

J. Within 10 calendar days of receiving the applicant's request for reconsideration, the Council shall notify the applicant, in writing, whether the denial is upheld. If a denial is upheld, the Council's notice upholding the denial shall include the following:
1. Reasons for the denial, with citations to the statutes or rules on which the denial is based;
2. The applicant's right to appeal the denial, including the number of days in which the applicant has to file a request for hearing to challenge the denial, and the right to request an informal settlement conference pursuant to A.R.S. § 41-1092.06;
3. The name and telephone number of an agency contact person who can answer questions regarding the appeal process.

K. An applicant whose certificate is denied has a right to a hearing, an opportunity for rehearing, and, if the denial is upheld, judicial review pursuant to A.R.S. Title 41, Chapter 6, Articles 6 and 10, and A.R.S. Title 12, Chapter 7, Article 6.

Historical Note
Adopted effective April 4, 1997 (Supp. 97-2).

R9-26-509. Certification Renewal

Certification of competency holders shall renew their certificates on or before January 1 of every year. If January 1 is a Saturday, Sunday, or legal holiday, the renewal deadline is the 1st business day following the Saturday, Sunday, or legal holiday. To renew certificates of competency, the certificate holder shall file all the following documentation with the Council:

1. A certified copy of the certificate holder's current RID, or NCRA, certification;
2. A notarized affidavit, signed by the certificate holder, attesting that since the Council issued the certificate, whether the certificate holder:
   a. Has been disciplined or is currently the subject of any disciplinary action in any jurisdiction, or before RID or NCRA, as applicable, relating to providing interpretation or realtime reporting services, respectively, or adhering to the RID or NCRA ethical requirements of R9-26-503(C) or R9-26-507(C), respectively;
   b. Has been named as a defendant in any law suit alleging that the certificate holder was negligent in providing interpretation services, or alleging the certificate holder violated the RID ethical requirements of R9-26-503(C), or alleging the certificate holder was negligent in providing realtime reporting services, or alleging the certificate holder violated the NCRA ethical requirements of R9-26-507(C);
   c. Follows the RID ethical requirements of R9-26-503(C), or NCRA ethical requirements of R9-26-507(C), as applicable;
   d. Understands that it is the certificate holder's duty to ensure that the certificate holder's interpreting, or translating, skills meet the deaf person's communication needs, and that failure to do so may be grounds for revocation of the certificate holder's certificate of competency;
   e. Has completed the requirements necessary to maintain RID, or NCRA certification and understands the certificate holder shall continue to maintain current RID, or NCRA certification;
   f. Has completed at least 3 clock hours of continuing legal education since the effective date, or the last renewal date of the certificate of competency, whichever is more recent; and
   g. Has maintained accurate records of compliance with the continuing legal education requirements of this Article, and shall make these records available for examination upon this Council's request.
3. The certificate holder's current name, address, and telephone number.

Historical Note
Adopted effective April 4, 1997 (Supp. 97-2).

R9-26-510. Certification Revocation

A. The Council may revoke a certificate of competency based on a complaint from any person alleging any of the following reasons:
1. The certificate holder has falsified any application or renewal information; or
2. The certificate holder has violated the RID or NCRA ethical requirements of R9-26-503(C) or R9-26-507(C), respectively.

B. A complaint alleging any of the reasons for revocation shall be in writing, with the name, address, telephone number, and signature of the person filing the complaint. A complaint may be written by someone on behalf of the complainant, but also

shall include the complainant's name, address, telephone number, and signature, indicating that the complaint is filed by the complainant. A complaint may be videotaped, with the complainant signing the complaint, but also shall include the complainant's name, address, and telephone number.

C. Within 20 calendar days of receiving a complaint, the Council shall mail the complaint to the certificate holder, and request the certificate holder to respond.

D. The certificate holder shall file a written response to the complaint with the Council, in writing, within 20 calendar days of the date that the complaint was mailed to the certificate holder.

E. The Council shall investigate the complaint and either dismiss the complaint, or send the matter to a formal hearing, within 60 calendar days of receiving the complaint. If no grounds are found to support the complaint, the Council shall dismiss the complaint.

F. If the complaint is sent to a formal hearing, the hearing shall be conducted pursuant to A.R.S. Title 41, Chapter 6, Articles 6 and 10. A party to the hearing has an opportunity for rehearing or review, and judicial review pursuant to A.R.S. Title 41, Chapter 6, Article 10, and A.R.S. Title 12, Chapter 12, Article 6.

Historical Note
Adopted effective April 4, 1997 (Supp. 97-2).

R9-26-511. Rehearing or Review of Decisions

A. If a party to an appealable agency action or contested case files a Motion for Rehearing or Review with the Council, it shall be filed not later than 30 calendar days after service of the decision, and shall specify the particular grounds for the motion. For purposes of this subsection, a decision shall be deemed to have been served when personally delivered or mailed by certified mail to the party's last known residence or place of business.

B. A rehearing or review may only be granted for any of the following reasons materially affecting the moving party's rights, or ability to receive a fair hearing;

1. Any irregularity in the administrative hearing, any order or abuse of discretion by the administrative law judge or the Council;
2. Misconduct of the Council, or the administrative law judge, or prevailing party;
3. Accident or surprise which could not have been prevented by ordinary prudence;
4. Newly discovered material evidence which could not have been discovered with reasonable diligence and produced at the original hearing;
5. Excessive or insufficient penalties;
6. Error in the admission or rejection of evidence or other errors of law occurring at the administrative hearing; or
7. A decision which is not justified by the evidence or is contrary to law.

C. Not later than 15 calendar days after the Council's receipt of a motion for rehearing or review, the Council may affirm or modify its decision, or grant a rehearing or review. After giving the parties or their counsel notice and an opportunity to be heard, the Council may grant a rehearing or review for a reason not stated in the party's motion. An order modifying a decision or granting a rehearing or review shall specify with particularity the ground or grounds on which the rehearing or review is granted. The rehearing or review shall cover only those matters so specified.

D. Not later than 15 calendar days after a decision is rendered, the Council may on its own initiative order a rehearing or review for any of the reasons stated in subsection (B), after giving the parties or their counsel notice and an opportunity to be heard.

E. When a motion for rehearing or review is based upon affidavits, they shall be served with the motion. An opposing party shall have 10 calendar days from the date of service to serve opposing affidavits. This period may be extended by the Council for good cause up to 20 calendar days, or by written stipulation of the parties. If reply affidavits are permitted, they shall be served within 5 calendar days of service of the opposing affidavits.

Historical Note
Adopted effective April 4, 1997 (Supp. 97-2).

TITLE 9. HEALTH SERVICES

CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED

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ARTICLE 1. DEFINITIONS

R9-27-101. Definitions

In addition to the definitions contained in A.R.S. Title 36, Chapter 29, unless the context explicitly requires another meaning:

1. "AHCCCS" means the Arizona Health Care Cost Containment System.
2. "Ambulance" means any vehicle defined in A.R.S. § 36-2201(2).
3. "Clean claim" means one that can be processed without obtaining additional information from the provider of the service or from a 3rd party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
4. "Coinsurance" means a predetermined amount a member agrees to pay to a provider for covered services. A coinsurance payment is a percentage of the fee schedule rate for the services.
5. "Copayment" means a monetary amount specified by the Healthcare Group Administration which a member or dependent pays directly to a provider at the time covered services are rendered.
6. "Covered services" means the health and medical services described in R9-27-202.
7. "Day" means a calendar day unless otherwise specified in the text.
8. "Deductible" means a fixed annual dollar amount a member agrees to pay for certain covered services before the Healthcare Group Plan agrees to pay.
9. "Dependent" means the eligible spouse and children of an employee member under R9-27-303.
10. "Eligible employee" means an employee who is eligible for Healthcare Group coverage under R9-27-302.
11. "Emergency ambulance service" means:
    a. Transportation by an ambulance or air ambulance company for persons requiring emergency medical services.
    b. Emergency medical services that are provided by a person certified by the Arizona Department of Health Services to provide the services before, during, or after a member is transported by an ambulance or air ambulance company.
12. "Emergency medical services" means medical services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:
    a. Placing the patient's health in serious jeopardy;
    b. Serious impairment to bodily functions; or
    c. Serious dysfunction of any bodily organ.
13. "Employer group" means the aggregate enrollment of an employed group or business that is contracting with a Healthcare Group Plan for covered services.
14. "Employee member" means an enrolled employee of an employer group.
15. "Enrollment" means the process by which an employer group or member applies for coverage and contracts with a Healthcare Group Plan.
16. "Full-time employee" means an employee who works at least 20 hours per week and expects to continue employment for at least 5 months following enrollment.
17. "Grievance" means a complaint arising from an adverse action, decision, or policy by a Healthcare Group Plan, subcontractor, noncontracting provider, or the Healthcare Group Administration, presented by an individual or entity specified in R9-27-601.
18. "Group Service Agreement (GSA)" means a contract between an employer group and a Healthcare Group Plan.
19. "Healthcare Group of Arizona (HCG)" means the registered name of the Healthcare Group Program, which is a prepaid medical coverage product marketed by the Healthcare Group Plans to small uninsured businesses and political subdivisions within the state.
20. "Healthcare Group Administration (HCGA)" means the section within AHCCCS that directs and regulates the continuous development and operation of the HCG Program.
21. "Healthcare Group Plan (HCG Plan or Plan)" means a prepaid health plan that is currently under contract with the HCGA to provide covered services.
22. "Hospital" means a health care institution licensed as a hospital by the Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is determined by AHCCCS to meet the requirements for certification under Title XVIII of the Social Security Act, as amended.
23. "Inpatient hospital services" means medically necessary services that require an inpatient stay in an acute care hospital. Inpatient hospital services are provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.
24. "Life threatening" means any condition for which a delay in obtaining pre-authorization or traveling to an approved medical facility would have a severe adverse effect on the patient's condition.
25. "Medical record" means a single, complete record kept at the site of a member's primary care provider which documents the medical services received by the member, including inpatient discharge summary, outpatient care, and emergency care.
26. "Medical services" means services pertaining to medical care that are performed at the direction of a physician, on behalf of members by physicians, nurses, or other health care practitioners and technical personnel.
27. "Medically necessary" means covered services provided by a physician or other health care practitioner within the scope of the health care practitioner's practice under state law to:
    a. Prevent disease, disability, and other adverse health conditions or their progression; or
    b. Prolong life.
28. "Member" means an employee or dependent who is enrolled with a HCG Plan.
29. "Noncontracting provider" means a provider who renders covered services to a member but who does not have a subcontract with the member's HCG Plan.
30. "Other health care practitioner" means a person other than a physician who is licensed or certified under Arizona law to deliver health care services.
31. "Outpatient services" means medically necessary services that may be provided in any setting on an outpatient basis (does not require an overnight stay in an inpatient hospital). Outpatient services are provided by or under the direction of a physician or other health care practitioner, upon referral from a member's primary care provider.
32. "Pharmaceutical services" means medically necessary drugs prescribed by a physician, a practitioner, or dentist upon referral by a primary care provider and dispensed in accordance with R9-27-207.

33. "Physician services" means services provided within the scope of practice of medicine or osteopathy as defined by state law or by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy.
34. "Political subdivision" means the state of Arizona or a county, city, town, or school district within the state.
35. "Primary care practitioner" means a physician's assistant or a registered nurse practitioner who is certified and practicing in an appropriate affiliation with a physician, as authorized by law.
36. "Pre-existing condition" means an illness or injury that is diagnosed or treated within the 12-month period preceding the effective date of coverage.
37. "Premium" means the monthly prepayment submitted to HCGA by the employer group.
38. "Pre-payment" means submission of the employer group's premium payment 30 days in advance of the effective date of coverage in accordance with R9-27-306.
39. "Prescription" means an order to a provider for covered services, which is signed or transmitted by a provider licensed under applicable state law to prescribe or order the services.
40. "Primary care provider" means a patient's primary care physician or a primary care practitioner.
41. "Prior authorization" means the process by which the HCG Plan authorizes, in advance, the delivery of covered services.
42. "Quality management" means a methodology used by professional health personnel to assess the degree of conformance to desired medical standards and practices and to implement activities designed to continuously improve and maintain quality service and care, and which is performed through a formal program with involvement of multiple organizational components and committees.
43. "Referral" means the process by which a primary care provider directs a member to another appropriate provider or resource for diagnosis or treatment.
44. "Rider or contract rider" means an amendment to the group service agreement between an employer group and a HCG Plan.
45. "Scope of services" means the covered, limited, and excluded services listed in R9-27-201 through R9-27-210.
46. "Service area" means the geographic area designated by HCGA where each HCG Plan shall provide covered health care benefits to members directly or through subcontracts.
47. "Spouse" means the husband or wife of a HCG member who has entered into a marriage recognized as valid by Arizona.
48. "Subcontract" means an agreement entered into by a HCG Plan with any of the following:
    a. A provider of health care services who agrees to furnish covered services to members;
    b. A marketing organization; or
    c. Any other organization.
49. "Subscriber" means an enrolled employee of an employer group.
50. "Subscriber agreement" means a contract between an employee member and HCG Plan.
51. "Utilization control" means an overall accountability program encompassing quality management and utilization review.
52. "Utilization review" means a methodology used by professional health personnel to assess the medical indications, appropriateness, and efficiency of care provided.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective April 30, 1992 (Supp. 92-2).
Amended effective July 15, 1997 (Supp. 97-3).

ARTICLE 2. SCOPE OF SERVICES

R9-27-201. Scope of Services

A. Each HCG Plan shall provide, either directly or through subcontracts, the covered services specified in this Article.
B. The HCG Plans shall ensure that covered services are provided by, or under the direction of, a primary care provider.
C. The scope of covered services and excluded services may be further delineated or limited in the Group Service Agreement.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-202. Covered Services

A. Subject to the exclusions and limitations specified in these rules, the following services shall be covered by the HCG Plans:
    1. Outpatient services;
    2. Laboratory, radiology, and medical imaging services;
    3. Prescription drugs;
    4. Inpatient hospital services;
    5. Emergency medical services in and out of the service area;
    6. Emergency ambulance services; and
    7. Maternity care.
B. The scope of covered services may be expanded or reduced through a rider to the group service agreement with the prior written consent of the HCGA.
C. Any medical service not specifically provided for in this Article or in a rider is not a covered service.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-203. Excluded Services

The following services shall not be covered:
    1. Services or items furnished solely for cosmetic purposes;
    2. Services or items requiring prior authorization for which prior authorization has not been obtained;
    3. Services or items furnished gratuitously or for which charges are not usually made;
    4. Hearing aids, eye examinations for prescriptive lenses, and prescriptive lenses;
    5. Long-term care services, including nursing services;
    6. Private or special duty nursing services, provided in a hospital unless medically necessary and prior authorized by the Plan Medical Director.
    7. Care for health conditions that are required by state or local law to be treated in a public facility;
    8. Care for military service disabilities treatable through governmental facilities if the member is legally entitled to treatment and the facilities are reasonably available;
    9. Gastric stapling or diversion for weight loss;
    10. Reports, evaluations, or physical examinations not required for health reasons including, but not limited to, employment, insurance, or governmental licenses, and court-ordered forensic or custodial evaluations;

11. Treatment of temporomandibular joint dysfunction, unless treatment is prior authorized and determined by the Plan Medical Director or designee to be medically necessary;
12. Elective abortions;
13. Medical and hospital care and costs for the child of a dependent, unless the child is otherwise eligible under the GSA;
14. Nonmedical ancillary services including vocational rehabilitation, employment counseling, psychological counseling and training, and physical therapy for learning disabilities;
15. Sex change operations and reversal of voluntarily induced infertility (sterilization);
16. Services not deemed medically necessary by the Plan Medical Director, or the responsible primary care provider;
17. Routine foot care;
18. Blood and blood products;
19. Human organ transplants, except for cornea and kidney transplants;
20. Mental health services;
21. Durable medical equipment;
22. Artificial implants;
23. Dental services;
24. Transportation other than emergency ambulance services;
25. Psychotherapeutic drugs;
26. Charges for injuries incurred as the result of participating in a riot, or committing, or attempting to commit a felony or assault, or by suicide attempt;
27. Early and periodic screening, diagnosis and treatment services (EPSDT); and
28. In vitro fertilization.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective April 30, 1992 (Supp. 92-2).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-204. Out-of-service Area Coverage
In accordance with R9-27-209, a member's out-of-area care is limited to emergencies when the member is traveling or temporarily outside of the member's HCG Plan's service area.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended July 15, 1997 (Supp. 97-3).

R9-27-205. Outpatient Health Services
The HCG Plans shall provide the following outpatient services:

1. Ambulatory surgery and anesthesiology services not specifically excluded;
2. Physician's services;
3. Pharmaceutical services and prescribed drugs to the extent authorized by these rules, and applicable provider contracts;
4. Laboratory services;
5. Radiology and medical imaging services;
6. Services of other health care practitioners when supervised by a physician;
7. Nursing services provided in an outpatient health care facility;
8. The use of emergency, examining, or treatment rooms when required for the provision of physician's services;
9. Home physician visits, as medically necessary;
10. Specialty care physician services referred by a primary care provider;
11. Physical examinations, periodic health examinations, health assessments, physical evaluations, or diagnostic work-ups that include tasks or procedures to:
    a. Determine risk of disease;
    b. Provide early detection of disease;
    c. Detect the presence of injury or disease at any stage;
    d. Establish a treatment plan for injury or disease at any stage;
    e. Evaluate the results or progress of a treatment plan or treatment decision; or
    f. Establish the presence and characteristics of a physical disability that may be the result of disease or injury.
12. Short-term rehabilitation and physical therapy may be provided for a 60-day period, if in the judgment of the Plan Medical Director or designee, the treatment can be expected to result in the significant improvement of a member's condition.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-206. Laboratory, Radiology, and Medical Imaging Services
The HCG Plans shall provide laboratory, radiology, and medical imaging services, prescribed by the member's primary care provider, which are ordinarily provided in hospitals, clinics, physicians' offices, and other health facilities by licensed or certified health care providers, if medically necessary. Clinical laboratory, radiology, or medical imaging service providers must satisfy all applicable state and federal license and certification requirements and shall provide only services that are within the categories stated in the provider's license or certification.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-207. Pharmaceutical Services

A. The HCG Plans shall ensure that pharmaceutical services are available to members during customary business hours. The services shall be located within reasonable travel distance within the Plan's service area.

B. The HCG Plans shall adhere to the following limitations when providing a pharmaceutical service:

1. Drugs personally dispensed by a physician or dentist are not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
2. Prescription drugs are prescribed up to a 30-day supply unless the HCG Plan determines a longer supply is more cost effective.
3. Immunosuppressant (anti-rejection) drugs are covered except when prescribed as part of the post-operative treatment for noncovered organ transplants. However, if a member is taking immunosuppressant drugs at the time of enrollment as part of the post-operative treatment for any organ transplant, the drugs are not covered.
4. Only drugs that are not available over-the-counter are covered.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-208. Inpatient Hospital Services

A. The HCG Plans shall provide the following inpatient hospital services:

1. Routine services, including:
   a. Hospital accommodations;
   b. Intensive care and coronary care units;
   c. Nursing services necessary and appropriate for the member's medical condition;
   d. Dietary services;
   e. Medical supplies, appliances, and equipment ordinarily furnished to hospital inpatients, billed as part of routine services, and included in the daily room and board charge;
2. Ancillary services, including:
   a. Labor, delivery and recovery rooms, and birthing centers;
   b. Surgery and recovery rooms;
   c. Laboratory services;
   d. Radiological and medical imaging services;
   e. Anesthesiology services;
   f. Rehabilitation services;
   g. Pharmaceutical services and prescribed drugs;
   h. Respiratory therapy;
   I. Maternity services;
   j. Nursery and related services;
   k. Chemotherapy; and
   l. Dialysis as limited by these rules.

B. Limitations. The HCG Plans shall adhere to the following limitations when providing inpatient hospital services:
1. Inpatient hospital accommodations are limited to no more than a semi-private rate, except when patients must be isolated for medical reasons.
2. Dialysis is limited to services not covered by Title XVIII, of the Social Security Act, as amended.
3. Alternative levels of care instead of hospitalization are covered when determined cost effective and medically necessary by the Plan's Medical Director, or designee.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-209. Emergency Medical Services

A. Emergency medical services provided within the Plan's service area. Emergency medical services shall be available to members 24 hours a day, 7 days a week. The member or provider shall notify the Plan within 24 hours after the initiation of treatment. If a member is incapacitated, the provider is responsible for notifying the Plan. Failure to provide timely notice constitutes cause for denial of payment.

B. Emergency medical services provided outside the Plan's service area which cannot be postponed until the member is able to return to the service area are covered. The member or provider shall notify the Plan within 48 hours after the initiation of treatment. If a member is incapacitated, the provider is responsible for notifying the Plan. Failure to provide timely notice constitutes cause for denial of payment.

C. Ambulance services.
1. Within the Plan's service area. A member shall be entitled to emergency ambulance services within the Plan's service area. The provider shall notify the Plan within 10 working days after providing emergency ambulance service to a member. Failure to provide timely notice constitutes cause for denial of payment.
2. Outside the Plan's service area. A member shall be entitled to ambulance services outside the Plan's service area to transport the member to the nearest medical facility capable of providing required emergency services. The provider shall notify the Plan within 10 working days after providing emergency ambulance service to a member. Failure to provide timely notice constitutes cause for denial of payment.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-210. Pre-existing Conditions

A. Subject to subsection (C), a HCG Plan shall not cover inpatient services related to a pre-existing condition for 12 months from the effective date of coverage.

B. A HCG Plan shall not cover inpatient costs for the delivery of a child for 10 months from the effective date of coverage.

C. A HCG Plan shall not impose a pre-existing condition exclusion against an eligible employee who meets the following standards:
1. Newborns from the time of their birth;
2. Eligible employees who meet the portability requirements of A.R.S. § 20-2308:
   a. A person who had continuous coverage for a 1-year period and during that year had no breaks in coverage totaling more than 31 days; and
   b. The person's prior coverage ended within 60 days before the date of application for enrollment.

D. A HCG Plan shall apply a credit toward meeting the 12 month pre-existing condition exclusion of 1 month for each month of continuous coverage that an eligible employee had under another HCG Plan or accountable health plan in accordance with A.R.S. § 36-2912. Upon request, a contracted health plan or an accountable health plan which provided continuous coverage to an individual shall promptly disclose the coverage provided.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective October 12, 1988 (Supp. 88-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-211. Repealed

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Repealed effective July 15, 1997 (Supp. 97-3).

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-27-301. Eligibility Criteria for Employer Groups

A. An employer group shall conduct business within Arizona for at least 60 days before making application to be an employer group eligible for HCG coverage. This shall be determined by 1 or more of the following:
1. Participation in state unemployment insurance;
2. Participation in state worker's compensation;
3. Possession of a state tax identification number; and
4. Other verifiable proof that the applicant is conducting a business in Arizona.

B. An employer group other than the state of Arizona and political subdivisions of the state, shall have a minimum of 1 and a maximum of 40 full-time employees at the effective date of its 1st contract with a HCG Plan. Acceptable proof of the number of full-time employees may include canceled checks, bookkeeping records, and personnel ledgers.

C. Other than state employees and employees of political subdivisions of the state, 50% of the eligible employees in a group must enroll in order for the employer group to contract with a HCG Plan. Employees with proof of other medical coverage who do not wish to participate in the HCG shall not be considered in determining the percentage.

D. Changes in group size that occur during the term of the Group Service Agreement shall not affect eligibility.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended subsection (C) effective October 12, 1988 (Supp. 88-4). Amended effective March 31, 1992 (Supp. 92-1). Amended effective April 30, 1992 (Supp. 92-2). Amended effective September 13, 1993 (Supp. 93-3). Amended effective July 15, 1997 (Supp. 97-3).

R9-27-302. Eligibility Criteria for Employee Members

A. Employee members shall reside, work, or reside and work in Arizona.

B. Employee members shall be employed by an eligible employer group specified in R9-27-301.

C. Employee members shall have been employed at least 60 consecutive days before the effective date of coverage.

D. Employee members or self-employed persons shall work for the employer group at least 20 hours per week, with anticipated employment of at least 5 months following enrollment.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3).

R9-27-303. Eligibility Criteria for Dependents

A. Eligible dependents of employee members include:
1. A legal spouse;
2. Unmarried children less than the age of 19 or less than the age of 24 if a full-time student:
   a. Natural child;
   b. Adopted child;
   c. Step-child;
   d. Child supported by the employee member under a valid court order; and
   e. Child for whom the employee member is a legal guardian; and
3. A child incapable of self-sustaining support by reason of mental or physical disability existing before the child's 19th birthday, as determined by the Plan Medical Director or designee.

B. Limitations. A grandchild of an employee member shall be eligible to receive covered services only if the grandchild meets the eligibility requirements of R9-27-303(A)(2) and (3).

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3).

R9-27-304. Employer Group Member Eligibility Verification

A. The HCG Plan shall determine the eligibility status of the employer group and members.

B. Eligibility verification may be conducted at random or for cause by the HCGA or HCG Plan.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3).

R9-27-305. Health History Form

Before enrollment, all eligible employees and dependents shall complete the HCG health history form. An eligible employee or dependent shall not be denied enrollment as a result of conditions described on the health history form. However, a pre-existing condition will limit the benefits available to a member. Failure to provide complete and accurate information on the health history form is cause for immediate termination from the HCG Plan.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3).

R9-27-306. Effective Date of Coverage

Employer groups shall submit payment 30 days in advance of the effective date of coverage; the effective date of coverage shall be the 1st day of the month for which the premium has been pre-paid.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3).

R9-27-307. Open Enrollment of Employee Members

A. Enrollment of employee members shall occur only during 1 of the following open enrollment periods:
1. Thirty days following the effective date of the Group Service Agreement for newly enrolled employer groups;
2. A 30-day period to start 60 days from the date of employment for a new employee in an enrolled employer group, or a 30-day period after the completion of an employer's waiting period on eligibility for health care coverage, whichever period is greater; and
3. A 30-day period to begin 105 days and conclude at least 75 days before the employer group's renewal date, as determined by the HCGA.

B. Enrollment of new dependents shall occur within the 30-day period following the acquisition of a new dependent and in accordance with R9-27-308 if the dependent is a newborn.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective April 30, 1992 (Supp. 92-2). Amended effective July 15, 1997 (Supp. 97-3).

R9-27-308. Enrollment of Newborns

All newborns shall be enrolled within 30 days of birth to be eligible for coverage. Upon enrollment, the newborn's premium is due to the HCGA within 30 days of birth for coverage retroactive to the 1st day of the month in which the birth occurred.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3).

R9-27-309. Enrollment of Newly Eligible Employee and Dependent Due to Loss of Own Coverage

A. Eligible employee due to loss of own coverage. An eligible employee who had health care through a spouse, shall be eligible to enroll as a member within 30 days of the loss of coverage, if that loss of separate coverage was due to:
1. Death of the eligible employee's spouse;
2. Divorce; or
3. Termination of employment of the eligible employee's spouse.

B. Eligible dependent due to loss of own coverage. An eligible dependent, who had individual or family coverage separate from the member's coverage and who loses that coverage due to termination of employment or retirement, shall be eligible to enroll as a dependent member within 30 days of the loss of coverage.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3).

R9-27-310. Denial and Termination of Enrollment

A. An employer group, employee, or dependent who fails to meet the requirements of this Article shall be denied enrollment.

B. Termination of enrollment and coverage for an employer group, employee member, or dependent shall occur on the last day of the month in which:
1. The employer group loses eligibility;

2. The employee member loses eligibility; or
3. The dependent loses eligibility.

C. The HCG Plan may exclude employer groups or employee members from enrollment who have committed fraud or misrepresentation while enrolled with another HCG Plan or health benefits carrier.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

ARTICLE 4. CONTRACTS, ADMINISTRATION AND STANDARDS

R9-27-401. General

A. Contracts to provide services under the HCG program shall be established between the HCGA and qualified HCG Plans in accordance with the applicable provisions in this Article and A.R.S. Title 36.

B. Contracts and subcontracts entered into under this Article shall become public records on file with the HCGA unless otherwise made confidential by law.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-402. Contracts

A. To contract with the HCGA, a health plan must meet the requirements of A.R.S. § 36-2912.

B. Each contract shall be in writing and contain, at a minimum, the following information:

1. The method and amount of compensation or other consideration to be received by the HCG Plan;
2. The name and address of the HCG Plan;
3. The population and geographic service area to be covered by the contract;
4. The amount, duration, and scope of medical services to be provided, or for which compensation will be paid;
5. The term of the contract, including the beginning and ending dates, as well as methods of extension, re-negotiation, and termination;
6. A provision that the HCG Plan arrange for the collection of any required copayment, coinsurance, deductible, and 3rd-party insurance;
7. A provision that the HCG Plan will not bill or attempt to collect from a member for any covered service except as may be authorized by statute, these rules, or contract riders that have been approved by the HCGA;
8. A provision that the contract will not be assigned or transferred without the prior written approval of the HCGA;
9. Procedures for enrollment of the covered population;
10. Procedures and criteria for terminating or suspending the contract; and
11. A provision that the HCG Plan will hold harmless and indemnify the state, AHCCCS, HCGA, and members against claims, liabilities, judgments, costs, and expenses with respect to 3rd parties, which may accrue against the state, AHCCCS, HCGA, or members, through the negligence or other action of the HCG Plan.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-403. Subcontracts

A. Approval. Any subcontract entered into by a HCG Plan to provide covered services to HCG members is subject to review and approval of the HCGA. No subcontract alters the legal responsibility of the HCG Plan to the HCGA to ensure that all activities under the contract are carried out.

B. Subcontracts. Each subcontract shall be in writing and include:

1. A specification that the subcontract will be governed by and construed under all laws, rules, and contractual obligations of the HCG Plan.
2. A provision that the HCG Plan will notify the HCGA in the event the subcontract with the HCG Plan is amended or terminated.
3. A provision that assignment or delegation of the subcontract is void unless prior written approval is obtained from the HCGA.
4. An agreement to hold harmless the state, AHCCCS, the HCGA, and members in the event the HCG Plan is unable to or does not pay for covered services performed by the subcontractor.
5. A provision that the subcontract and subcontract amendments are subject to review and prior written approval by the HCGA and that a subcontract or subcontract amendment may be terminated, rescinded, or canceled by the HCGA for violation of a provision of these rules.
6. An agreement to hold harmless and indemnify the state, AHCCCS, the HCGA, and members against claims, liabilities, judgments, costs, and expenses with respect to 3rd parties, which may accrue against the state, AHCCCS, the HCGA, or members, through the negligence or other action of the subcontractor.
7. The method and amount of compensation or other consideration to be received by the subcontractor.
8. The amount, duration, and scope of medical services to be provided by the subcontractor, for which compensation will be paid.

C. A HCG Plan may submit a written request to the HCGA requesting a waiver of the requirement that the Plan subcontract with a hospital in the Plan's service area. The request shall state the reasons for requesting a waiver and all efforts that have been made to secure a subcontract with a hospital within the Plan's service area. For good cause shown, the HCGA may waive the hospital subcontract requirement. The HCGA shall consider the following criteria in deciding whether to waive the hospital subcontract requirement:

1. The number of hospitals in the service area;
2. The extent to which the HCG Plan's primary care providers have staff privileges at noncontracting hospitals in the service area;
3. The size and population of, and the demographic distribution within, the service area;
4. The patterns of medical practice and care within the service area;
5. Whether the HCG Plan has diligently attempted to negotiate a hospital subcontract in the service area;
6. Whether the HCG Plan has any subcontracts in adjoining areas with hospitals that are reasonably accessible to the Plan's members in the service area; and
7. Whether the HCG Plan's members can reasonably be expected to receive all covered services in the absence of a hospital subcontract.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-404. Contract Amendments

Any merger, reorganization, or change in ownership of a HCG Plan or subcontractor affiliated with the HCG Plan shall constitute a contract amendment. The HCG Plan shall obtain written approval from the HCGA, before any merger, reorganization, or change in owner-

ship of the HCG Plan or subcontractor that is related to or affiliated with the HCG Plan. To be effective, contract amendments shall be submitted in writing to the HCGA and executed by both parties.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-405. Contract Termination

A. Contract between the HCGA and HCG Plan. The HCGA may suspend, deny, refuse, fail to renew, or terminate a contract or require the HCG Plan to terminate a subcontract for good cause which may include the following reasons:
1. Submission of any misleading, false, or fraudulent information;
2. Provision of any services in violation of or not authorized by licensure, certification, or other law;
3. A material breach of contract;
4. Failure to provide and maintain quality health care services to members, as determined by standards established by the state; and
5. Failure to reimburse a medical provider within 60 days of receipt of a clean claim unless a different period is specified by contract.

B. Group Service Agreement between HCG Plan and employer group.
1. The GSA may be terminated with written notice from either the HCG Plan or employer to the other party no more than 60 days, and at least 45 days before the anniversary date of the GSA.
2. The GSA may be terminated by the HCG Plan for cause with 10 days' written notice for the following:
   a. Material misrepresentation of information furnished by the employer to the Plan, or
   b. Employer's default in payment of premiums time being of the essence.
3. The GSA may be terminated by the employer group or the HCG Plan with 45 days' written notice for a material breach of the contract.

C. Termination of an employee member by the HCGA or HCG Plan.
1. Cause for immediate termination of coverage. The HCGA or HCG Plan may terminate an employee member's coverage for the following:
   a. Fraud or misrepresentation when applying for coverage or obtaining services; or
   b. Violence, or threatening or other substantially abusive behavior toward the HCGA or the HCG Plan employees or agents, or contracting or noncontracting providers or their employees or agents.
2. Cause for termination with 30 days written notice. The HCGA or the HCG Plan may terminate coverage of an employee member for the following reasons:
   a. Repeated and unreasonable demands for unnecessary medical services;
   b. Failure to pay any copayment, coinsurance, deductible, or required financial obligation; and
   c. Material violation of any provision of the Group Service Agreement.
3. Termination by reason of ineligibility.
   a. Termination of employment;
   b. Failure of employer or employee to pay premium. Termination shall be effective the 1st day of the month for which the premium has not been paid;
   c. Coverage of a dependent member shall automatically cease on the last day of the month in which the dependent member loses coverage, for any reason described in R9-27-406 and R9-27-407.
   d. Subject to continuation coverage and conversion coverage, as described in R9-27-406 and R9-27-407, on the effective date of termination of coverage, the HCG Plan shall have no further obligation to provide services and benefits to a member whose coverage has been terminated; except that a member confined to a hospital at the effective date of termination shall continue to receive coverage until there has been a determination by the HCG Plan Medical Director or designee that care in the hospital is no longer medically necessary for the condition for which the member was admitted to the hospital; and
   e. An employee member whose coverage terminates according to this subsection shall not be eligible for re-enrollment until the employer group's next open enrollment period. The employee shall meet all the eligibility criteria prescribed by these rules before re-enrollment.

D. The HCG Plan may exclude employer groups or employee members from enrollment who have committed fraud or misrepresentation while enrolled with another HCG Plan or health benefits carrier.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended subsection (C) effective October 12, 1988 (Supp. 88-4). Amended effective July 15, 1997 (Supp. 97-3).

R9-27-406. Continuation Coverage

Employer groups with at least 20 employees on a typical business day during the preceding calendar year shall provide continuation coverage as required by 29 U.S.C. 1161 et seq., December 19, 1989, incorporated by reference and on file with the HCGA and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments. The employer group shall collect the premium from the employee and pay the premium to HCGA.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-407. Conversion Coverage

This Section applies only to employee members and dependents of employer groups with fewer than 20 employees.

1. An employee member, dependent, or a qualified beneficiary who loses eligibility for a qualifying event, as defined in 29 U.S.C. 1163, and who has been covered for at least 3 months under the GSA may convert the policy to an individual policy for a period of 180 days.
2. A member shall have 30 days after the date of termination of group coverage to convert the coverage and pay the initial premium. Any services used within the 30-day conversion period before payment of the initial premium shall not be covered unless the care was provided or authorized by the member's primary care provider or the HCG Plan.
3. A member shall pay the premium for the converted coverage directly to the HCGA. Converted coverage shall be retroactive to the date of termination of group coverage.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective April 30, 1992 (Supp. 92-2).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-408. Repealed

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Repealed effective July 15, 1997 (Supp. 97-3).

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-27-501. Availability and Accessibility of Services

A. HCG Plans shall ensure that, within each service area, an adequate number of hospitals, medical care facilities, and service providers are available and reasonably accessible to provide covered services, to members. At a minimum, a HCG Plan shall:

1. Have a designated emergency medical services facility, providing care 24 hours a day, 7 days a week. Emergency medical services facilities shall be accessible to members in each service area with at least 1 physician and nurse on call or on duty at the facility at all times.
2. Have an emergency medical services system employing at least 1 physician, registered nurse, physician's assistant, or nurse practitioner, accessible by telephone 24 hours a day, 7 days a week, to provide information to providers who need verification of patient membership and treatment authorization; and in the case of an emergency as defined under emergency medical services in R9-27-101.
3. Maintain an emergency medical services call log that contains the following information:
   a. Member's name,
   b. Member's address,
   c. Member's telephone number,
   d. Date of call,
   e. Time of call, and
   f. Instructions given to each member.
4. A written procedure plan for the communication of emergency medical services information to the member's primary care provider and other appropriate organizational units.
5. An appointment system for each of the HCG Plan's service locations. The appointment system shall ensure that:
   a. Members with acute or urgent problems are triaged and provided same-day service when necessary;
   b. Time-specific appointments for routine medically necessary care from the primary care provider are available within 3 weeks of a member's request and on the same day for emergency care; and
   c. Referral appointments to specialists are in the same day for emergency care, within 3 days for urgent care, and within 30 days for routine care.
6. One primary care provider that an enrolled member may select or to whom the member may be assigned. HCG Plans whose organization does not ordinarily include primary care providers shall enter into affiliation or subcontract with an organization or individuals to provide primary care. The HCG Plans shall agree to provide services under the primary care provider's guidance and direction. The primary care provider is responsible for:
   a. Supervising, coordinating, and providing initial and primary care to patients;
   b. Initiating referrals for specialty care; and
   c. Maintaining continuity of patient care.
7. Primary care physicians and specialists providing inpatient services to members must have staff privileges in a minimum of 1 general acute care hospital under subcontract with the contracting health plan, within or near the service area of the HCG Plan.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended July 15, 1997 (Supp. 97-3).

R9-27-502. Reinsurance

A. Reinsurance may be provided by the HCGA through private reinsurers.

B. For purposes of the HCGA's reinsurance program, the insured entities shall be the HCG Plans with which the HCGA contracts.

1. A specified amount per member, per month, shall be deducted by the HCGA from the HCG Plan's monthly premium to cover the cost of the reinsurance contract.
2. The HCG Plan shall comply with the reimbursement requirements of the reinsurance agreement between the reinsurer and the HCGA.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended subsection (A) effective October 12, 1988 (Supp. 88-4). Amended effective July 15, 1997 (Supp. 97-3).

R9-27-503. Marketing, Prohibition Against Inducements, Misrepresentation, Discrimination, Sanctions

A. Marketing representatives shall not misrepresent themselves, the HCG Plan or the HCG program through false advertising, false statements, or in any other manner in order to induce members of other contracting entities to enroll in a particular HCG Plan.

B. Marketing representatives shall not claim, infer, or falsely represent themselves to be employees of the state or representatives of the HCGA, a county, or a HCG plan other than the HCG Plan with whom they are employed or by whom they are reimbursed.

C. Marketing representatives shall not engage in any marketing or other pre-enrollment practices that discriminate against an eligible person or member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.

D. HCG Plans shall bear responsibility for the performance of any marketing representative, subcontractor or agent, program, or process under their employ or direction.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-504. Approval of Advertisements and Marketing Material

A. The HCG Plans shall submit to the HCGA for review and approval proposed marketing strategies and marketing materials before distributing the marketing materials or implementing any activities. The proposed marketing strategies and materials shall be submitted in writing to the HCGA.

B. The HCGA shall review and approve or disapprove all proposed marketing materials and strategies. The HCGA shall notify the HCG Plan in writing of the approval or disapproval of the proposed marketing materials and marketing strategies. The notification shall include a statement of objections and recommendations.

C. To minimize the expense of revising marketing materials or other copy, a HCG Plan may submit the material in draft form subject to final approval and filing of a proof or final copy.

D. HCG Plans shall submit 2 copies of the proof or final approved copy of materials to the HCGA, which shall maintain the proof or copy for 5 years.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-505. Member Records and Systems
Each HCG Plan shall maintain a member service record that contains encounter data, grievances, complaints, and service information for each member.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-506. Fraud or Abuse
All HCG Plans, providers, and nonproviders shall advise the HCGA immediately in writing of suspected fraud or abuse.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-507. Release of Safeguarded Information

A. Information to be safeguarded concerning an applicant or member of a HCG Plan includes:
1. Name, address, and social security number;
2. Evaluation of personal information; and
3. Medical data and services including diagnosis and history of disease or disability.

B. Unrestricted information. The restrictions upon disclosure of information shall not apply to summary data, utilization data, and other information that does not identify an individual applicant or member.

C. Safeguarded information concerning a member or applicant shall be disclosed only to:
1. The member or applicant, or, in the case of a minor, the parent, custodial relative, or guardian;
2. Individuals authorized by the member or applicant; and
3. Persons or agencies for official purposes.
4. Safeguarded information may be released to these parties only under the conditions specified in subsections (D), (E), and (F).

D. A member or authorized representative may view the member's medical record after written notification to the provider and at a reasonable time and place.

E. Release to individuals authorized by the individual concerned. A HCG Plan shall release medical records and any other HCG-related confidential information of a member or applicant to individuals authorized by the member or applicant only under the following conditions:
1. Authorization for release of information must be obtained from the member, applicant, or authorized representative. In the case of a minor, the member's or applicant's parent, custodial relative, or guardian shall submit an authorization for release of information.
2. Authorization used for release of information must be, submitted in writing separate from any other document, and must specify the following:
   a. Information or records, in whole or in part, which are authorized for release;
   b. To whom the release shall be made;
   c. The period of time for which the authorization is valid, if limited; and
   d. The dated signature of the member, applicant, or authorized representative. In the case of a minor member or applicant, signature of a parent, custodial relative, or guardian is required unless the minor is able to understand the consequences of authorizing and not authorizing.
3. If a grievance or appeal has been filed, the grievant, appellant, or designated representative shall be permitted to review, obtain, or copy any nonprivileged record necessary for the proper presentation of the case. The grievant or appellant also may authorize release of safeguarded information deemed necessary to the contested issue, to any opposing party in the case.

F. Release to persons or agencies for official purposes.
1. Safeguarded information, case records, and medical services information may be disclosed without the consent of the member, to agents or employees of a review committee.
2. For purposes of this Section, "review committee" means an organizational structure within the Plan whose primary purpose is to:
   a. Evaluate and improve the quality of health care;
   b. Review and investigate the conduct of licensed health care providers to determine whether disciplinary action should be imposed; and
   c. Encourage proper and efficient utilization of health care services and facilities.
3. Any member, agent, or employee of a review committee, who in good faith and without malice, furnishes records, information, or assistance related to the duties of the review committee; or, who takes an action or makes a decision or recommendation related to the duties or functions of the review committee shall not be subject to liability for civil damages as a consequence of the action. This does not relieve a person of liability that arises from that person's medical treatment of a patient.
4. Information considered by a review committee related to the duties or functions of the committee, including records of their actions and proceedings, are confidential and are not subject to subpoena or order to produce except:
   a. When otherwise subject to discovery as a patient's medical records.
   b. In proceedings before an appropriate state licensing or certifying agency. If the information is transferred to an appropriate state licensing or certifying agency, the information shall be kept confidential and shall be subject to the same provisions concerning discovery and use in legal actions.
5. A member of a review committee or staff engaged in work for the committee or any other person assisting or furnishing information to the review committee shall not be subpoenaed to testify in a judicial or quasi-judicial proceeding if the subpoena is based solely on review committee activities.

G. Subcontracting providers shall not be required to obtain written approval from the member before transmitting member medical records to physicians:
1. Providing services to members under subcontract with the HCG Plan; or
2. Retained by the subcontractor to provide services that are infrequently used or are of an unusual nature.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-508. Repealed

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Repealed effective July 15, 1997 (Supp. 97-3).

R9-27-509. Information to Enrolled Members

A. Each HCG Plan shall produce and distribute a printed member handbook to each enrolled member by the effective date of coverage. The member handbook shall include the following:
1. A description of all available services and an explanation of any service limitation, and exclusions from coverage or charges for services, when applicable;
2. An explanation of the procedure for obtaining covered services, including a notice stating the HCG Plan shall only be liable for services authorized by a member's primary care provider or the Plan;
3. A list of the names, telephone numbers, and business addresses of primary care providers available for selection by the member, and a description of the selection process, including a statement that informs members they may request another primary care provider, if they are dissatisfied with their selection;
4. Locations, telephone numbers, and procedures for obtaining emergency health services;
5. Explanation of the procedure for obtaining emergency health services outside the HCG Plan's service area;
6. The causes for which a member may lose coverage;
7. A description of the grievance procedures;
8. Copayment, coinsurance, and deductible schedules;
9. Information on the appropriate use of health services and on the maintenance of personal and family health;
10. Information regarding emergency and medically necessary transportation offered by the HCG Plan; and
11. Other information necessary to use the program.

B. Notification of changes in services. Each HCG Plan shall prepare and distribute to members a printed member handbook insert describing any changes that the HCG Plan proposes to make in services provided within the Plan's service areas. The insert shall be distributed to all affected members or family units at least 14 days before a planned change. Notification shall be provided as soon as possible when unforeseen circumstances require an immediate change in services or service locations.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3).

R9-27-510. Discrimination Prohibition

A. A HCG Plan shall not discriminate against an applicant or member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex or physical or mental disability in accordance with Title VII of the U.S. Civil Rights Act of 1964, 42 U.S.C., Section 2000 D, regulations promulgated under the Act, or as otherwise provided by law or regulation. For the purpose of providing covered services under contract under A.R.S. Title 36, Chapter 29, discrimination on the grounds of race, creed, color, religion, ancestry, marital status, age, sex, national origin, sexual preference, or physical or mental disability includes, but is not limited to, the following:
1. Denying a member any covered service or availability of a facility for any reason except as defined in a rider provided under R9-27-202 or for a pre-existing condition as described in R9-27-210;
2. Providing to a member any covered service that is different, or is provided in a different manner or at a different time from that provided to other HCG members under contract, except where medically indicated;
3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service, or restricting a member in any way in the member's enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and
4. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, or physical or mental disability of the participants to be served.

B. A HCG Plan shall take affirmative action to ensure that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental disability, except where medically indicated.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended subsection (A), paragraph (1), effective October 12, 1988 (Supp. 88-4). Amended effective July 15, 1997 (Supp. 97-3).

R9-27-511. Equal Opportunity

A HCG Plan shall comply with the following equal opportunity employment requirements:
1. State in all solicitations or advertisements for employees placed by or on behalf of the HCG Plan, that it is an equal opportunity employer; and
2. Send a notice provided by the HCGA, to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding. The notice shall advise the labor union or workers' representative of the HCG Plan's commitment as an equal opportunity employer and shall be posted in conspicuous places available to employees and applicants for employment.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3).

R9-27-512. Periodic Reports and Information

A. Upon request by the HCGA, each HCG Plan shall furnish to the HCGA information from its records relating to contract performance.

B. Each HCG Plan shall maintain records to identify separately all HCG-related transactions.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3).

R9-27-513. Medical Audits

A. HCGA shall conduct a medical audit of each HCG Plan at least once every 12 months. Unless HCGA determines that advance notice will render a medical review less useful, the HCGA shall notify the HCG Plan approximately 3 weeks in advance of the date of an on-site medical review. HCGA may conduct, without prior notice, inspections of the HCG Plan facilities or perform other elements of a medical review, either in conjunction with the medial audit or as part of an unannounced inspection program.

B. As part of the medical audit, the HCGA may perform any or all of the following procedures:
1. Conduct private interviews and group conferences with:
   a. Members;
   b. Physicians and other health care practitioners;
   c. Members of the HCG Plan's administrative staff including, but not limited to, its principal management persons; and
2. Examine records, books, reports, and papers of the HCG Plan, any management company of the HCG Plan, and all

providers or subcontractors providing health care and other services to the HCG Plan. The examination may include, but is not limited to:
a. The minutes of medical staff meetings;
b. Peer review and quality of care review records;
c. Duty rosters of medical personnel;
d. Appointment records;
e. Written procedures for the internal operation of the HCG Plan;
f. Contracts;
g. Correspondence with members and with providers of health care services and other services to the HCG Plan; and
h. Additional documentation deemed necessary by the HCGA to review the quality of medical care.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-514. HCG Plan's Internal Quality Management and Utilization Review System
A. The HCG Plans shall comply with the following quality management and utilization review requirements:
1. Prepare and submit to HCGA for review and approval annually a written quality management plan which includes utilization review. The quality management plan must be designed and implemented with actions to promote the provision of quality health care services.
2. Design and implement procedures for continuously reviewing the performance of health care personnel and the utilization of facilities, services, and costs.
3. Medical records and systems.
   a. Ensure that member's medical records are maintained by the primary care provider, and include a record of all medical services received by the member from the HCG Plan and its subcontracting and noncontracting providers.
   b. Ensure that medical records are maintained in a manner that:
      i. Conforms to professional medical standards and practices;
      ii. Permits professional medical review and medical audit processes; and
      iii. Facilitates a system for follow-up treatment.
4. Develop and implement a program of utilization review methods for hospitals that, at a minimum, includes:
   a. Prior authorization of nonemergency hospital admissions;
   b. Concurrent review of inpatient stays; and
   c. Retrospective review of hospital claims to ensure that covered hospital services are not used unnecessarily or unreasonably.

B. The HCG Plan's utilization control system is subject to evaluation by the HCGA to determine cost effectiveness, and to measure whether quality management and utilization review methods are reducing, controlling, or eliminating unnecessary or unreasonable utilization. The HCG Plan may subcontract with an organization or entity designed to conduct activities regarding prior authorization, concurrent review, retrospective review, or any combination of these activities. A subcontract to conduct quality management or utilization review activities is subject to prior approval by the HCGA.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-515. Continuity of Care
A HCG Plan shall establish and maintain a system to ensure continuity of care which includes:
1. Referral of members needing specialty health care services;
2. Monitoring of members with chronic medical conditions;
3. Providing hospital discharge planning and coordination including post-discharge care; and
4. Monitoring the operation of the system through professional review activities.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-516. Financial Resources
A. A HCG Plan shall demonstrate to the HCGA that it has adequate financial reserves, administrative abilities, and soundness of program design to carry out its contractual obligations.
B. Contract provisions required by the HCGA may include, but are not limited to:
1. The maintenance of deposits,
2. Performance bonds,
3. Financial reserves, or
4. Other financial security.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

ARTICLE 6. GRIEVANCE AND APPEAL PROCESS

R9-27-601. Grievances and Appeals
A. The provisions of this Article provide the exclusive manner through which any individual or entity may grieve against the HCGA, the HCG Plans, or both in connection with any adverse action, decision, or policy.
B. Definitions. For the purpose of this Article:
1. "Appellant" means the individual or entity filing any grievance or appeal under this Article.
2. "Request for hearing" means an appeal of an adverse eligibility action; an appeal filed after an informal decision has been rendered on a grievance by the HCGA; an appeal of a grievance decision rendered by a HCG Plan; or an appeal filed because a HCG Plan has failed to render a timely grievance decision.
3. "Respondent" means the party responsible for the action being grieved or appealed. In most grievances, the HCG Plan is the respondent.

C. Filing grievances and appeals. Unless provided elsewhere in this Chapter, all grievances and appeals or other statements shall be considered filed when received in writing by the HCGA.
D. Computation of time. In computing any period of time for establishing timeliness of filing grievances and appeals, the period shall commence the day after the act, event, or decision grieved or appealed, and shall include all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period shall be extended until the end of the next day which is not a weekend or a legal holiday.
E. Direct grievances to the HCGA.
1. A grievance may be filed directly with the HCGA only by HCG Plans or by individuals or entities grieving an adverse action, decision, or policy actually made or enacted by the HCGA. If the aggrieved adverse action, decision, or policy actually was made by a HCG Plan, the appellant shall 1st file the grievance with the HCG Plan

responsible for the decision, policy or action being grieved, so that the HCG Plan may investigate and resolve the grievance in accordance with this Article and any applicable contracts.

2. Except as provided in subsection (E)(3), all written grievances shall be filed with and received by the HCGA not later than 35 days after the date of the adverse action, decision, or policy implementation being grieved.
3. Written grievances regarding claim denials shall be filed not more than 12 months after the date of the service for which payment is claimed. If the claim is denied less than 35 days before the expiration of the 12-month time period, the dissatisfied party shall have 35 days from the date of the denial to file the grievance.
4. All grievances shall state with particularity the factual and legal basis and the relief requested. Failure to comply with the specificity requirements shall result in the denial of the grievance.
5. The HCGA or its designee, in its sole discretion, may investigate the grievance and render a written informal decision before scheduling a hearing. A hearing shall be scheduled if any party timely requests a hearing within 15 days of the postmark date of the informal decision.
6. Pending final resolution of a grievance, appeal, or request for judicial review, a grieving HCG Plan shall proceed diligently with the performance of the contract and in accordance with the HCGA, its designee, or the Director's decision.
7. If a hearing is requested, it shall be conducted according to the provisions in this Article.

F. Grievances to HCG Plans.

1. Except as provided in subsection (F)(2), all grievances shall be filed with and received by the appropriate HCG Plan not later than 35 days after the date of the adverse action or decision.
2. Written grievances regarding claim denials shall be filed not more than 12 months after the date of the service for which payment is claimed. If the claim is denied less than 35 days before the expiration of the 12-month time period, the dissatisfied party shall have 35 days from the date of the denial to file the grievance.
3. All grievances shall state with particularity the factual and legal basis and the relief requested. Failure to comply with the specificity requirement shall result in the denial of the grievance.
4. A final decision shall be rendered by the HCG Plan on grievances that involve issues related to continuity or delivery of medical services within 15 days of filing. A final decision shall be rendered by the HCG Plan on all other grievances within 30 days of filing unless the parties agree on a longer period. The decision by the HCG Plan shall be personally delivered or mailed by certified mail to the parties, and it shall state the basis for the decision as well as the appellant's right to appeal the decision to the HCGA. The HCG Plan's final decision shall specify the manner in which an appeal to the HCGA may be filed.
5. The HCG Plan shall record and retain information to identify the appellant, date of receipt, and nature of the grievance.
6. At the time of enrollment, HCG Plans shall give to members written information regarding grievance procedures available through the HCG Plan and the HCGA.

G. Appeal of HCG Plan decisions to the HCGA.

1. After 1st grieving to the appropriate HCG Plan, an appellant may appeal to and request a hearing from the HCGA or designee if:
   a. The appellant files a written notice of appeal not more than 15 days after the date of the final decision of the HCG Plan, which is the earlier of the date of personal delivery or the postmark date of certified mail; or
   b. A decision is not timely rendered by the HCG Plan, and the appellant files a written notice of appeal based upon the HCG Plan's failure or refusal to timely decide the grievance.
2. The HCGA or its designee, in its sole discretion, may investigate the grievance and render a written informal decision before scheduling a hearing. A hearing shall be scheduled if any party timely requests a hearing within 15 days of the postmark date of the informal decision.
3. If a hearing is requested, it shall be conducted according to the provisions in this Article.

H. Appellant's hearing rights. The Administration shall afford an appellant the right to:

1. Have a hearing that is conducted as specified in A.R.S. §§ 41-1061 and 41-1062.
2. Obtain copies of any relevant documents from the respondent or from the HCGA at the appellant's expense.
3. Appear at the hearing and be heard in person, by telephone if available, through a representative designated in writing by the appellant, or to submit to the HCGA a written statement that is signed and notarized before the hearing.
4. Bring an interpreter to assist at the hearing.
5. Be provided an interpreter by the Administration if hearing-challenged according to A.R.S. § 12-242.

I. Withdrawal or denial of a request for hearing.

1. The HCGA or designee shall deny a request for hearing and deny a grievance or appeal if a written request for withdrawal is received from the appellant before the date of the hearing. The case file shall then be closed.
2. The HCGA or designee may deny a request for hearing and dismiss a grievance or appeal upon written determination if:
   a. The request for hearing is untimely;
   b. The request for hearing, grievance, or appeal is not for a reason permitted under this Article; or
   c. The appeal is otherwise moot.

J. Notice of Hearing. The Notice of Hearing shall be in accordance with A.R.S. § 41-1061 and shall include a statement detailing how an appellant may request a change in the scheduled hearing date.

K. Postponement.

1. The HCGA or designee's own motion may postpone a hearing. When a request for postponement is made by a party, it shall be in writing and received by the HCGA or designee no later than 5 days before the scheduled hearing date. The HCGA or designee may grant a request for postponement on a showing that:
   a. There is good cause for the postponement; and
   b. The cause is beyond the reasonable control of the party making the request.
2. If a postponement is granted, the hearing shall be rescheduled at the earliest practicable date.

L. Failure to appear for hearing. If any party or representative fails to appear at the hearing without good cause or a postponement, the HCGA or designee may:

1. Proceed with the hearing;
2. Reschedule the hearing with further notice;

3. Issue a decision based on the evidence of record; or
4. Issue a default disposition.

M. Conduct hearing. The hearing shall be conducted as specified in A.R.S. §§ 41-1061 and 41-1062.
1. The hearing shall be conducted in an informal manner without formal rules of evidence or procedure.
2. The HCGA or designee may:
   a. Hold prehearing conferences to settle, simplify, or identify issues in a proceeding, or to consider other matters that may aid in the expeditious disposition of the proceeding;
   b. Require parties to state their positions concerning the various issues in the proceeding;
   c. Require parties to produce for examination those relevant witnesses and documents under their control;
   d. Rule on motions and other procedural items;
   e. Regulate the course of the hearing and conduct of participants;
   f. Establish time limits for submission of motions or memoranda;
   g. Impose appropriate sanctions against any individual failing to obey an order under these procedures, which may include:
      i Refusing to allow the individual to assert or oppose designated claims or defenses, or prohibiting that individual from introducing designated matters in evidence;
      ii. Excluding all testimony of an unresponsive or evasive witness; and
      iii. Expelling the individual from further participation in the hearing.
   h. Take official notice of any material fact not appearing in evidence in the record, if the fact is among the traditional matter of judicial notice; and
   i. Administer oaths or affirmations.

N. Recommended decision. After the conclusion of the hearing, unless the appellant withdraws or the parties stipulate to a settlement, the hearing officer of the HCGA or designee shall prepare written findings of fact and conclusions of law and render a recommended decision to the Director.

O. Decision of the Director.
1. The Director may affirm, modify, or reject the recommended decision in whole or in part; may remand a matter to any party or the hearing officer with specific instructions; or make any other appropriate disposition.
2. The Director shall mail by certified mail a copy of the decision to all parties at their last known residences or places of business.

P. Petition for rehearing or review.
1. A party dissatisfied with the decision may petition the Director for rehearing or review of the decision for any of the following causes which materially affects the appellant's rights:
   a. Irregularity in the proceedings of the hearing or appeal that caused the aggrieved party to be deprived of a fair hearing or appeal;
   b. Misconduct of a party or the HCGA;
   c. Newly discovered material evidence, which with reasonable diligence could not have been discovered and produced at the hearing;
   d. That the decision is the result of passion or prejudice; or
   e. That the decision is not justified by the evidence or is contrary to law.
2. The petition for rehearing or review shall be filed not later than 15 days after the date of the Director's decision, which is the postmark date of the decision. The moving party shall also send a copy of the petition to all other parties. If a timely petition for rehearing or review is filed, the Director's decision is not a final administrative decision; rather, the Director shall render a final decision which is the final administrative decision.
3. The petition for rehearing or review shall be in writing and shall specifically state the grounds upon which it is based. The Director shall review the sufficiency of the evidence if the petition is made upon the ground that the decision is not justified by the evidence.
4. The Director may remand the case to any party; reopen the decision; order the taking of additional testimony or evidence before the hearing officer; amend findings of fact and conclusions of law; make new findings and conclusions; render an amended decision; or deny the petition and affirm the previous decision.
5. The Director, within the time for filing a petition for rehearing or review, may on the Director's own motion order a rehearing or issue an amended decision for any reason for which the Director might have done so upon petition of any party.

Q. Failure to submit a grievance, appeal, request for hearing, or petition for rehearing or review in a timely manner shall constitute a failure to exhaust administrative remedies required as a condition to seeking judicial relief.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Section repealed; new Section adopted effective July 15, 1997 (Supp. 97-3).

R9-27-602. Repealed

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Repealed effective July 15, 1997 (Supp. 97-3).

R9-27-603. Repealed

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Repealed effective July 15, 1997 (Supp. 97-3).

ARTICLE 7. STANDARD FOR PAYMENTS

R9-27-701. Scope of the HCGA's Liability; Payments to HCG Plans

A. The HCGA shall bear no liability for the provision of covered services or the completion of a plan of treatment to any member.

B. All payments to HCG Plans shall be made under the terms and conditions of contracts executed between the HCG Plan and HCGA in accordance with these rules.

C. The HCGA shall bear no liability for subcontracts that the HCG Plan executes with other parties for the provision of either administrative or management services, medical services, covered health care services, or for any other purpose. The HCG Plan shall indemnify and hold the HCGA harmless from any and all liability arising from the HCG Plan's subcontracts. The HCG Plan shall bear all costs of defense of any litigation over liability and shall satisfy in full any judgment entered against the HCGA arising from a HCG Plan subcontract. All deposits, bonds, reserves, and security posted under R9-27-516 shall be held by the HCGA to satisfy the obligations of this Section.

D. Premium payments, less HCGA administrative charges and reinsurance fees, shall be paid monthly to those HCG Plans

that have either posted required performance bonds or have otherwise provided sufficient security to the HCGA.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-702. Prohibition Against Charges to Members
No HCG Plan, subcontractor, noncontracting provider, or nonprovider reimbursed by a HCG Plan shall charge, submit a claim, demand, or otherwise collect payment from a member or person acting on behalf of a member for any covered service except to collect an authorized copayment, coinsurance, and deductible. This prohibition shall not apply if the HCGA determines that the member willfully withheld information pertaining to the member's enrollment in a Plan. HCG Plans shall have the right to recover from a member that portion of payment made by a 3rd party to the member when the payment duplicates HCG benefits and has not been assigned to the HCG Plan.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-703. Payments by HCG Plans
A. Payment for covered services. A HCG Plan shall pay for all covered services rendered to the Plan's members if the services were arranged by the Plan's agents or the Plan's employees, subcontracting providers, or other individuals acting on behalf of the HCG Plan and if necessary authorization was obtained.
B. Payment for medically necessary outpatient services. A HCG Plan shall reimburse subcontracting providers and noncontracting providers for covered health care services provided to the Plan's members. Reimbursement shall be made within the time period specified by contract between a HCG Plan and a subcontracting entity or within 60 days of receipt of a clean claim, if a time period is not specified.
C. Payment for instate inpatient and outpatient hospital services including emergency services. HCG Plans shall reimburse instate subcontracting providers for the provision of inpatient and outpatient hospital services, including emergency services, at the subcontracted rate. HCG Plans shall reimburse instate noncontracting providers for the provision of inpatient and outpatient hospital services, including emergency services, in accordance with the reimbursement methodology stipulated in A.R.S. § 36-2903.01(J).
1. HCG Plans shall pay for all emergency care services rendered their members by noncontracting providers if the services:
   a. Conform to the definition of emergency medical services in Article 1 and Article 2 of these rules; and
   b. Conform to the notification requirements in Article 2 of these rules.
2. HCG Plans shall provide written notice to providers whose claims are denied or reduced by the HCG Plan within 30 days of adjudication of the claims. This notice shall include a statement describing the provider's right to:
   a. Grieve the HCG Plan's rejection or reduction of the claim; and
   b. Submit a grievance to the HCGA, or its designee under Article 6 of these rules.

D. Payment for out-of-state inpatient and outpatient hospital services. The HCG Plans shall reimburse out-of-state subcontracting providers at the subcontracted rate. The HCG Plans shall reimburse out-of-state noncontracting providers for the provision of inpatient and outpatient hospital services at the lower of negotiated discounted rates or 80% of billed charges.
E. Payment for emergency ambulance services. The HCG Plans shall reimburse out-of-state subcontracting providers at the subcontracted rate. The HCG Plans shall reimburse noncontracting providers for emergency ambulance services at the lower of negotiated discounted rates or 80% of the billed charges.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-704. HCG Plan's Liability to Noncontracting and Nonprovider Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members
A. For purposes of HCG Plan liability, an emergency medical condition shall be subject to reimbursement only until the time the member's condition is stabilized and the member is transferable to a subcontractor, or until the member is discharged following stabilization, subject to the requirements of A.R.S. § 36-2909(E) and Article 2 of these rules.
B. Subject to subsection (A), if a member cannot be transferred following stabilization to a facility that has a subcontract with the HCG Plan of record, the HCG Plan shall pay for all appropriately documented medically necessary treatment provided the member before the date of discharge or transfer at the lower of a negotiated discounted rate or prospective tiered-per-diem rate.
C. If a member refuses transfer from a nonprovider or noncontracting hospital to a hospital affiliated with the member's HCG Plan, neither the HCGA nor the HCG Plan shall be liable for any costs incurred subsequent to the date of refusal if:
1. Subsequent to consultation with the member's HCG Plan, the member continues to refuse the transfer; and
2. The member has been provided and signs a written statement of liability, before the date of transfer informing the member of the medical and financial consequences of refusing to transfer. If the member refuses to sign a written statement, a statement signed by 2 witnesses indicating that the member was informed may be substituted.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

R9-27-705. Copayments
A. A member shall be required to pay a copayment directly to a provider at the time covered services are rendered.
B. The HCGA shall establish the amount of copayment a member shall be charged. The HCGA shall consider the following in determining the amount of copayment:
1. The impact the amount of the copayment will have on the population served; and
2. The copayment amount charged by other group health plans or health insurance carriers for particular services.

C. The HCGA shall include the copayment provisions in its contract with a HCG Plan.
D. The HCG Plans shall provide a schedule of the copayments to members at the time of enrollment.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Section repealed; new Section adopted effective July 15, 1997 (Supp. 97-3).

ARTICLE 8. COORDINATION OF BENEFITS

R9-27-801. Priority of Benefit Payment

A. HCG Plans shall coordinate all 3rd-party benefits. Services provided under the HCG are not intended to duplicate other services and benefits available to an employee member.

B. If a member has other coverage, payment for services shall occur in the following order:

1. A policy, plan, or program that has no coordination of benefits provision or nonduplication provision shall make payment 1st.
2. If a member is covered by another plan or policy which has coordination of benefits:
   a. The plan that provided or authorized the service shall make payment 1st.
   b. A plan that is not a prepaid plan that covers a person as an employee shall make payment before a plan that covers the person as a dependent.
3. If coverage is provided to a dependent child and both parents have family coverage:
   a. The plan of the employee whose birthday occurs 1st in the calendar year shall be primary, and the plan of the employee whose birthday occurs last in the calendar year shall be secondary.
   b. If both employees have the same birthday, the plan of the employee, that has been in force longer shall pay 1st.
   c. If 1 of the plans determines the order of benefits based upon the gender of an employee, and the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits.
4. If coverage is provided to a dependent child of divorced employees, the order of benefit shall be:
   a. The plan of the employee with custody of the child shall pay 1st;
   b. The plan of the spouse of the employee with custody of the child shall pay 2nd; and
   c. The plan of the employee not having custody of the child shall pay last.

C. HCG Plans shall not be primary payers for claims involving workers' compensation, automobile insurance, or homeowner's insurance.

D. HCG Plans shall not have lien or subrogation rights beyond those held by health care services organizations licensed under A.R.S. § Title 20, Chapter 4, Article 9.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4).
Amended effective July 15, 1997 (Supp. 97-3).

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ARIZONA LONG-TERM CARE SYSTEM

Editor's Note: This Chapter contains rules which were adopted under an exemption from the rulemaking provisions of the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6, §§ 1001 et seq.) as specified in Laws 1992, Ch. 301, § 61 and Ch. 302, § 13, and Laws 1994, Ch. 322, § 21. Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; AHCCCS did not submit these rules to the Governor's Regulatory Review Council; AHCCCS was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is being printed on blue paper. The rules affected by this exemption appear throughout this Chapter.

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Former Section R9-28-101 repealed; new Sections R9-28-101 thru R9-28-111 adopted effective December 8, 1997 (Supp. 97-4).

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Article 11, consisting of Sections R9-28-1101 through R9-28-1106, adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Governor's Regulatory Review Council did not review these rules; AHCCCS was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

Section
R9-28-1101. Definitions
R9-28-1102. Eligibility
R9-28-1103. Service Delivery System
R9-28-1104. ALTCS-covered Behavioral Health Services
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ARTICLE 12. MEMBERS' RIGHTS AND RESPONSIBILITIES

Section R9-28-1201 adopted effective September 9, 1998 (Supp. 98-3).

Section
R9-28-1201. Rights and Responsibilities

ARTICLE 1. DEFINITIONS

R9-28-101. General Definitions

A. Location of definitions. Definitions applicable to this Chapter are found in the following:

	Definition	Section or Citation
1.	"211"	R9-28-104
2.	"217"	R9-28-104
3.	"236"	R9-28-104
4.	"Administration"	A.R.S. § 36-2931
5.	"AFDC"	R9-22-101
6.	"Aggregate"	R9-22-107
7.	"AHCCCS"	R9-22-101
8.	"AHCCCS hearing officer"	R9-22-108
9.	"ALTCS"	A.R.S. § 36-2932
10.	"ALTCS acute care services"	R9-28-104
11.	"Alternative HCBS setting"	R9-28-101
12.	"Ambulance"	R9-22-102
13.	"Appeal"	R9-22-108
14.	"Bed hold"	R9-28-102
15.	"Behavior intervention"	R9-28-102
16.	"Billed charges"	R9-22-107
17.	"Capped fee-for-service"	R9-22-101
18.	"Case management plan"	R9-28-101
19.	"Case manager"	R9-28-101
20.	"Case record"	R9-22-101
21.	"Categorically eligible"	A.R.S. § 36-2934
22.	"Certification"	R9-28-105
23.	"CFR"	R9-28-101
24.	"Clean claim"	A.R.S. § 36-2904
25.	"Community Spouse"	R9-28-104
26.	"Community Spouse Resource Deduction"	R9-28-104
27.	"Comprehensive plan for delivery of services"	R9-28-105
28.	"Contract"	R9-22-101
29.	"Contractor"	R9-22-101
30.	"County of fiscal responsibility"	R9-28-107
31.	"Covered services"	R9-22-102
32.	"CPT"	R9-22-107
33.	"CSRD"	R9-28-104
34.	"Day"	R9-22-101
35.	"Developmental disability"	A.R.S. § 36-551
36.	"Diagnostic services"	R9-22-102
37.	"Disenrollment"	R9-22-117
38.	"DME"	R9-22-102
39.	"Eligible person"	A.R.S. § 36-2931
40.	"Emergency medical services"	R9-22-102
41.	"Encounter"	R9-22-107
42.	"Enrollment"	R9-22-117
43.	"Estate"	A.R.S. § 14-1201
44.	"Facility"	R9-22-101
45.	"Factor"	R9-22-101
46.	"Fair consideration"	R9-28-104
47.	"FBR"	R9-22-101
48.	"Grievance"	R9-22-108
49.	"Guardian"	R9-22-116
50.	"HCBS"	A.R.S. §§ 36-2931 and 36-2939
51.	"Home"	R9-28-101
52.	"Home health services"	R9-22-102
53.	"Hospital"	R9-22-101
54.	"ICF-MR"	R9-28-101
55.	"IHS"	R9-28-101
56.	"IMD"	42 CFR 435.1009
57.	"Inspection of care"	R9-28-105
58.	"Institutionalized"	R9-28-104
59.	"JCAHO"	R9-28-101
60.	"License" or "licensure"	R9-22-101

61.	"Medical record"	R9-22-101
62.	"Medical services"	R9-22-101
63.	"Medical supplies"	R9-22-102
64.	"Medically eligible"	R9-28-104
65.	"Medically necessary"	R9-22-101
66.	"Member"	A.R.S. § 36-2931
67.	"MMMNA"	R9-28-104
68.	"NF"	42 U.S.C. 1396r(a)
69.	"Noncontributing provider"	A.R.S. § 36-2931
70.	"Occupational therapy"	R9-22-102
71.	"PAS"	R9-28-103
72.	"PASARR"	R9-28-103
73.	"Pharmaceutical service"	R9-22-102
74.	"Physical therapy"	R9-22-102
75.	"Physician"	R9-22-102
76.	"Post-stabilization services"	42 CFR 438.114
77.	"Practitioner"	R9-22-102
78.	"Primary care provider"	R9-22-102
79.	"Primary care provider services"	R9-22-102
80.	"Prior authorization"	R9-22-102
81.	"Private duty nursing services"	R9-22-102
82.	"Program contractor"	A.R.S. § 36-2931
83.	"Provider"	A.R.S. § 36-2931
84.	"Prudent layperson standard"	42 U.S.C. 1396u-2
85.	"Quality management"	R9-22-105
86.	"Radiology"	R9-22-102
87.	"Reassessment"	R9-28-103
88.	"Redetermination"	R9-28-104
89.	"Referral"	R9-22-101
90.	"Reinsurance"	R9-22-107
91.	"Representative"	R9-28-104
92.	"Respiratory therapy"	R9-22-102
93.	"Respite care"	R9-28-102
94.	"RFP"	R9-22-105
95.	"Room and board"	R9-28-102
96.	"Scope of services"	R9-22-102
97.	"Speech therapy"	R9-22-102
98.	"Spouse"	R9-28-104
99.	"SSA"	P.L. 103-296, Title I
100.	"SSI"	R9-22-101
101.	"Subcontract"	R9-22-101
102.	"Utilization management"	R9-22-105
103.	"Ventilator dependent"	R9-28-102

B. General definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

1. "AHCCCS" is defined in 9 A.A.C. 22, Article 1.
2. "ALTCS" means the Arizona Long-Term Care System as authorized by A.R.S. § 36-2932.
3. "Alternative HCBS setting" means a living arrangement approved by the Director and licensed or certified by a regulatory agency of the state, where a member may reside and receive HCBS including:
   a. For a person with a developmental disability (DD) specified in A.R.S. § 36-551:
      i. Community residential setting defined in A.R.S. § 36-551;
      ii. Group home defined in A.R.S. § 36-551;
      iii. State-operated group home defined in A.R.S. § 36-591;
      iv. Family foster home defined in 6 A.A.C. 5, Article 58;
      v. Group foster home defined in 6 A.A.C. 5, Article 59;
      vi. Licensed residential facility for a person with traumatic brain injury specified in A.R.S. § 36-2939(C); and
      vii. Behavioral health service agency specified in A.R.S. § 36-2939(B)(2) and 9 A.A.C. 20, Articles 6, 7, and 8 for Levels I, II, or III;
   b. For a person who is elderly or physically disabled (EPD), provided the facility, setting, or institution is registered with AHCCCS:
      i. Adult foster care homes defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939, and an assisted living home or a residential unit, as defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939.
      ii. Licensed residential facility for a person with a traumatic brain injury specified in A.R.S. § 36-2939(C); and
      iii. Behavioral health service agency specified in A.R.S. § 36-2939(C) and 9 A.A.C. 20, Articles 6, 7, and 8 for levels I and II.
4. "Case management plan" means a service plan developed by a case manager that involves the overall management of a member's or an eligible person's care, and the continued monitoring and reassessment of the member's or the eligible person's need for services.
5. "Case manager" means a person who is either a degreed social worker, a licensed registered nurse, or a person with a minimum of 2 years of experience in providing case management services to a person who is elderly and physically disabled or has developmental disabilities.
6. "CFR" means Code of Federal Regulations, unless otherwise specified in this Chapter.
7. "Contract" is defined in 9 A.A.C. 22, Article 1.
8. "Contractor" is defined in 9 A.A.C. 22, Article 1.
9. "Day" is defined in 9 A.A.C. 22, Article 1.
10. "Disenrollment" is defined in 9 A.A.C. 22, Article 1.
11. "Eligible person" has the meaning in A.R.S. § 36-2931.
12. "Enrollment" is defined in 9 A.A.C. 22, Article 1.
13. "Facility" is defined in 9 A.A.C. 22, Article 1.
14. "Factor" is defined in 9 A.A.C. 22, Article 1.
15. "HCBS" means home and community based services defined in A.R.S. §§ 36-2931 and 36-2939.
16. "Home" means a residential dwelling that is owned, rented, leased, or occupied at no cost to a member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion and any of these, licensed or certified by a regulatory agency of the state as a:
   a. Health care institution defined in A.R.S. § 36-401;
   b. Residential care institution defined in A.R.S. § 36-401;
   c. Community residential facility defined in A.R.S. § 36-551; or
   d. Behavioral health service facility defined in 9 A.A.C. 20, Articles 6, 7, and 8.
17. "Hospital" is defined in 9 A.A.C. 22, Article 1.
18. "ICF-MR means an intermediate care facility for the mentally retarded and is defined in 42 CFR 435.1009 and 440.150.
19. "IHS" means the Indian Health Services.
20. "JCAHO" means the Joint Commission on Accreditation of Healthcare Organizations.
21. "License" or "licensure" is defined in 9 A.A.C. 22, Article 1.
22. "Medical record" is defined in 9 A.A.C. 22, Article 1.

23. "Medical services" is defined in 9 A.A.C. 22, Article 1.
24. "Medically necessary" is defined in 9 A.A.C. 22, Article 1.
25. "Member" has the meaning in A.R.S. § 36-2931.
26. "NF" means nursing facility and is defined in 9 A.A.C. 22, Article 1.
27. "Noncontracting provider" has the meaning in A.R.S. § 36-2931.
28. "Program contractor" has the meaning in A.R.S. § 36-2931.
29. "Provider" has the meaning in A.R.S. § 36-2931.
30. "Referral" is defined in 9 A.A.C. 22, Article 1.
31. "SSA" means Social Security Administration defined in P.L. 103-296, Title I.
32. "SSI" is defined in 9 A.A.C. 22, Article 1.
33. "Subcontract" is defined in 9 A.A.C. 22, Article 1.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1).

R9-28-102. Covered Services Related Definitions
Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

1. "Ambulance" is defined in 9 A.A.C. 22, Article 1.
2. "Bed hold" means a 24 hour per day unit of service that is authorized by an ALTCS case manager or designee during a period of short-term hospitalization or therapeutic leave that meets the requirement specified in 42 CFR 483.12.
3. "Behavior intervention" means the planned interruption of an eligible person's or member's inappropriate behavior using techniques such as reinforcement, training, behavior modification, and other systematic procedures intended to result in more acceptable behavior.
4. "Covered services" is defined in 9 A.A.C. 22, Article 1.
5. "Diagnostic services is defined in 9 A.A.C. 22, Article 1.
6. "DME" means durable medical equipment and is defined in 9 A.A.C. 22, Article 1.
7. "Emergency medical services" is defined in 9 A.A.C. 22, Article 1.
8. "Home health services" is defined in 9 A.A.C. 22, Article 1.
9. "Medical supplies" is defined in 9 A.A.C. 22, Article 1.
10. "Occupational therapy" is defined in 9 A.A.C. 22, Article 1.
11. "Pharmaceutical service" is defined in 9 A.A.C. 22, Article 1.
12. "Physician" is defined in 9 A.A.C. 22, Article 1.
13. "Physical therapy" is defined in 9 A.A.C. 22, Article 1.
14. "Practitioner" is defined in 9 A.A.C. 22, Article 1.
15. "Primary care provider" is defined in 9 A.A.C. 22, Article 1.
16. "Primary care provider services" is defined in 9 A.A.C. 22, Article 1.
17. "Prior authorization" is defined in 9 A.A.C. 22, Article 1.
18. "Private duty nursing services" is defined in 9 A.A.C. 22, Article 1.
19. "Radiology services" is defined in 9 A.A.C. 22, Article 1.
20. "Respiratory therapy" is defined in 9 A.A.C. 22, Article 1.
21. "Respite care" means a short-term service provided in a NF or a home and community based service setting to an individual when necessary to relieve a family member or other person caring for the individual.
22. "Room and board" means lodging and meals.
23. "Scope of services" is defined in 9 A.A.C. 22, Article 1.
24. "Speech therapy" is defined in 9 A.A.C. 22, Article 1.
25. "Ventilator dependent", for purposes of ALTCS eligibility, means an individual is medically dependent on a ventilator for life support at least 6 hours per day and has been dependent on ventilator support as an inpatient in a hospital, NF, or ICF-MR for 30 consecutive days.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4).

R9-28-103. Preadmission Screening Related Definitions
Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

1. "Case record" is defined in 9 A.A.C. 22, Article 1.
2. "Developmental disability" means a disability described in A.R.S. § 36-551.
3. "Guardian" is defined in 9 A.A.C. 22, Article 1.
4. "Minor" is defined in 9 A.A.C. 22, Article 1.
5. "PAS" means preadmission screening, which is the process of determining an individual's risk of institutionalization at a NF or ICF-MR level of care, as specified in Article 3 of this Chapter.
6. "PASARR" means preadmission screening and annual resident review, which is the 2-step screening process for mental illness and mental retardation according to A.R.S. § 36-2936. The level I screening is used to identify potentially mentally ill (MI) or mentally retarded (MR) individuals before nursing facility admission. The level II screening used to make an in-depth assessment of potentially MI or MR individuals referred through the level I screening and to determine the appropriateness of nursing facility care and the need for special services for the MI or MR individual.
7. "Reassessment" means the process of redetermining PAS eligibility for ALTCS services on an annual or periodic basis, as appropriate, for all members and eligible persons.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4).

R9-28-104. Eligibility and Enrollment Related Definitions
Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

1. "211" means 42 CFR 435.211.
2. "217" means 42 CFR 435.217.
3. "236" means 42 CFR 435.236.
4. "ALTCS acute care services" means services, under 9 A.A.C. 22, Articles 2 and 12, that are provided to a person who meets ALTCS eligibility requirements in 9 A.A.C. 28, Article 4 but who lives in an acute care living arrangement described in R9-28-406(B) or who is

not eligible for long-term benefits, described in R9-28-409(D), due to a transfer without receiving equal compensation.

5. "Community spouse" means the husband or wife of a person who has entered into a contract of marriage, recognized as valid by Arizona, and who does not live in a medical institution.
6. "Community Spouse Resource Deduction" means the amount of a married couple's resources that are excluded in the eligibility determination to prevent impoverishment of the community spouse, determined under R9-28-410(B).
7. "CSRD" means Community Spouse Resource Deduction defined in R9-28-104(6).
8. "Fair consideration" means income, real or personal property, services, or support and maintenance equal to the fair market value of the income or resources that were transferred.
9. "Institutionalized" means residing in a medical institution or receiving or expecting to receive HCBS that prevent the person from being placed in a medical institution determined by the ALTCS Pre-Admission Screening (PAS) under R9-28-103.
10. "Medically eligible" means meeting the ALTCS medical eligibility criteria under 9 A.A.C. 28, Article 3.
11. "MMMNA" means Minimum Monthly Maintenance Needs Allowance.
12. "Redetermination" means a periodic review of all eligibility factors for a recipient.
13. "Representative" means a person other than a spouse or a parent of a dependent child, who applies for ALTCS on behalf of another person.
14. "Spouse" means either someone who is legally married under Arizona law, a person who is eligible for Social Security benefits as the spouse of another person, or a person who lives with another person of the opposite sex and the couple represents themselves in their community as husband and wife.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4). Amended effective November 4, 1998 (Supp. 98-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-105. Program Contractor and Provider Standards Related Definitions
Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

1. "Certification" means a voluntary process by which a federal or state regulatory entity grants recognition to an individual, facility, or organization which has met certain prerequisite qualifications specified by the regulatory entity and which may assume or use the word "certified" in his, her, or its title or designation to perform prescribed health professional tasks.
2. "Comprehensive plan for delivery of services" means the plan that program contractors submit to the Director as prescribed in A.R.S. § 36-2940.
3. "Inspection of care" means an annual review of members and eligible persons residing in ICF-MRs, behavioral health residential treatment centers, inpatient psychiatric facilities for individuals less than age of 21, and IMDs to ensure appropriate placement, utilization, and quality of care.
4. "Quality management" is defined in 9 A.A.C. 22, Article 1.
5. "Utilization management" is defined in 9 A.A.C. 22, Article 1.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4).

R9-28-106. Program Contracts and Procurement Process Related Definitions
Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22 Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning: "RFP" means request for proposal and is defined in 9 A.A.C. 22, Article 1.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4).

R9-28-107. Standards for Payments Related Definitions
Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

1. "Aggregate" is defined in 9 A.A.C. 22, Article 1.
2. "Billed charges" is defined in 9 A.A.C. 22, Article 1.
3. "Capped fee-for-service" is defined in 9 A.A.C. 22, Article 1.
4. "Clean claim" is defined in 9 A.A.C. 22, Article 1.
5. "CPT" is defined in 9 A.A.C. 22, Article 1.
6. "County of fiscal responsibility" means the county that is financially responsible for the state's share of ALTCS funding.
7. "Encounter" is defined in 9 A.A.C. 22, Article 1.
8. "Reinsurance" is defined in 9 A.A.C. 22, Article 1.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4). Amended effective November 4, 1998 (Supp. 98-4).

R9-28-108. Grievance and Appeal Related Definitions
Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1 have the following meanings unless the context of the Chapter explicitly requires another meaning:

1. "AHCCCS hearing officer" is defined in 9 A.A.C. 22, Article 1.
2. "Appeal" is defined in 9 A.A.C. 22, Article 1.
3. "Grievance" is defined in 9 A.A.C. 22, Article 1.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4).

R9-28-109. 1st-and 3rd-party Liability Related Definitions
Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning: "Estate" has the meaning in A.R.S. § 14-1201.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4).

R9-28-110. Reserved

R9-28-111. Behavioral Health Services Related Definitions
Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning: "IMD" means an institution for mental disease as defined in 42 CFR 435.1009.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4).

ARTICLE 2. COVERED SERVICES

R9-28-201. General Requirements
In addition to the exclusions and limitations specified in this Article, ALTCS services shall be:

1. Medically necessary, cost effective, and federally reimbursable;
2. Coordinated by a case manager in accordance with requirements specified in R9-28-510;
3. Prior authorized by an eligible person or member's program contractor or by the Administration, when this authorization is required:
   a. Services may be denied if required prior authorization is not obtained.
   b. Services provided during a retroactive period of eligibility are exempt from prior authorization requirements.
4. Provided in facilities or areas of facilities, licensed or certified according to Article 5, or meet other requirements described in Article 5;
5. Rendered by providers registered with the Administration as authorized to provide the service; and
6. Provided at an appropriate level of care, as determined by the case manager or the primary care provider.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Section repealed; new Section adopted effective September 22, 1997 (Supp. 97-3).

R9-28-202. Medical Services
The Administration and its contractors shall cover medical services and provisions specified in 9 A.A.C. 22, Article 2 and Article 12 for ALTCS members and eligible persons, subject to the limitations and exclusions specified in those Articles, unless otherwise specified in this Chapter.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective September 22, 1997 (Supp. 97-3).

R9-28-203. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Repealed effective September 22, 1997 (Supp. 97-3).

R9-28-204. Institutional Services

A. Institutional services shall be provided in:
1. A nursing facility as defined in R9-28-101;
2. An "ICF-MR" as defined in R9-28-101; or
3. An "IMD" as defined in R9-28-101.

B. The Administration and its contractors shall include the following services in the per diem rate for these facilities:
1. Nursing care services;
2. Rehabilitative services;
3. Restorative services;
4. Social services;
5. Nutritional and dietary services;
6. Recreational therapies and activities;
7. Medical supplies and durable medical equipment described in 9 A.A.C. 22, Article 2;
8. Overall management and evaluation of a member's or eligible person's care plan;
9. Observation and assessment of a member's or eligible person's changing condition;
10. Room and board services, including, but not limited to, supporting services such as food and food preparation, personal laundry, and housekeeping;
11. Non-prescription, stock pharmaceuticals; and
12. Respite services not to exceed 30 days per contract year.

C. Each facility shall be responsible for coordinating the delivery of at least the following auxiliary services:
1. As specified in 9 A.A.C. 22, Article 2:
   a. Medical services;
   b. Pharmaceutical services;
   c. Diagnostic services;
   d. Emergency services; and
   e. Emergency and medically necessary transportation services.
2. Therapy services, as specified in R9-28-206.

D. Limitations. The following limitations apply:
1. A nursing facility, ICF-MR, or IMD shall place a member or eligible person in a private room only if:
   a. The member or eligible person has a medical condition that requires isolation, and
   b. The member's or eligible person's primary care provider gives written authorization.
2. Each ICF-MR shall meet the standards in A.R.S. § 36-2939(B)(1), and in 42 CFR, Part 483, Subpart I, February 28, 1992, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no further editions or amendments.
3. Convalescent care shall be excluded as a covered service for members and eligible persons specified in A.R.S. Title 36, Chapter 29, Article 1;
4. Bed hold days for the Administration's fee-for-service providers shall meet the following criteria:
   a. Short-term hospitalization leave is limited to 12 days per AHCCCS contract year, and is available when an eligible person is admitted to a hospital for a short stay. After the short-term hospitalization, the eligible person is returned to the institutional facility from which leave was taken, and the same bed if the level of care required can be provided in that facility bed; and
   b. Therapeutic leave is limited to 9 days per AHCCCS contract year. A physician order is required for leave from the facility for 1 or more overnight stays to enhance psycho-social interaction, or as a trial basis for discharge planning. After the therapeutic leave, the eligible person is returned to the same bed within the institutional facility;
5. The Administration or its contractors shall cover services that are not part of a per diem rate but are ALTCS covered services included in this Article, and deemed necessary by a member's or eligible person's case manager or the case manager's designee if:

a. The services are ordered by the member's or eligible person's primary care provider; and
b. The services are specified in a case management plan according to R9-28-510.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsections (A) and (D) effective June 6, 1989 (Supp. 89-2). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective September 22, 1997 (Supp. 97-3).

R9-28-205. Home and Community Based Services (HCBS)

A. Subject to the availability of federal funds, HCBS are covered services when provided to a member or eligible person residing in a HCBS setting. Room and board services are not covered in a HCBS setting.

B. The case manager shall authorize and specify in a case management plan any additions, deletions, or changes in home and community based services provided to a member or eligible person in accordance with R9-28-510.

C. Home and community based services shall include the following:
1. Home health services provided on a part-time or intermittent basis. These services include:
   a. Nursing care;
   b. Home health aide;
   c. Medical supplies, equipment, and appliances;
   d. Physical therapy;
   e. Occupational therapy;
   f. Respiratory therapy; and
   g. Speech and audiology services;
2. Medical supplies and durable medical equipment, including customized DME, as described in 9 A.A.C. 22, Article 2;
3. Transportation services to obtain ALTCS covered medically necessary services;
4. Adult day health services provided to a member or eligible person who is not developmentally disabled as defined by A.R.S. § 36-551, in an adult day health care facility licensed according to 9 A.A.C. 10, Article 5, including:
   a. Planned care supervision and activities;
   b. Personal care;
   c. Personal living skills training;
   d. Meals and health monitoring;
   e. Preventive, therapeutic, and restorative health related services; and
   f. Behavioral health services, provided either directly or through referral, if medically necessary;
5. Personal care services;
6. Homemaker services;
7. Home delivered meals, which provide at least 1/3 of the recommended dietary allowance, for a member or eligible person who is not developmentally disabled as defined in A.R.S. § 36-551;
8. Respite care services for no more than 720 hours per contract year;
9. Habilitation services including:
   a. Physical therapy;
   b. Occupational therapy;
   c. Speech and audiology services;
   d. Training in independent living;
   e. Special development skills;
   f. Sensory-motor development;
   g. Behavior intervention; and
   h. Orientation and mobility training;
10. Developmentally disabled day care for an eligible person or member who is developmentally disabled, as defined by A.R.S. § 36-551, provided in a group setting during a portion of a 24-hour period, and to include:
   a. Planned care supervision and activities;
   b. Personal care;
   c. Activities of daily living skills training; and
   d. Habilitation services; and
11. Supported employment services provided to a member or eligible person who is an ALTCS transitional developmentally disabled HCBS person as defined by A.R.S. § 36-551 and in R9-28-306.

Historical Note
Adopted effective September 22, 1997 (Supp. 97-3).

R9-28-206. ALTCS Services that may be Provided to Members or Eligible Persons Residing in either Institutional or HCBS Settings

The Administration shall cover the following ALTCS services when the services are provided to a member or eligible person within the limitations listed:
1. Occupational and physical therapies, speech and audiology services, and respiratory therapy:
   a. The duration, scope, and frequency of each therapeutic modality or service is prescribed by the member's or eligible person's primary care provider or attending physician;
   b. These therapies and services are authorized by the member's program contractor or the Administration for an eligible person; and
   c. These therapies and services are included in the member's or eligible person's case management plan.
2. Medical supplies, durable medical equipment, and customized durable medical equipment:
   a. These supplies or equipment conform with the requirements and limitations of 9 A.A.C. 22, Article 2; and
   b. For billing purposes, supplies and equipment are limited to items not included by the Administration under the rates in Article 7 of this Chapter for the providers of the services.
3. Ventilator dependent services:
   a. Inpatient or institutional services for a ventilator dependent member are limited to services provided in a general hospital, special hospital, nursing facility, or ICF-MR. Services provided in a general or special hospital are included in the hospital's unit tier rate; or
   b. In addition to authorized home and community based services specified in this Section, private duty nursing services are covered only for a ventilator dependent member or eligible person residing in a HCBS setting.
4. Hospice services:
   a. Hospice services are covered only for a member or eligible person who is in the final stages of a terminal illness and has a prognosis of death within 6 months;
   b. Services available to a member or eligible person receiving hospice care are limited to those allowable under 42 CFR Part 418, December 20, 1994, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This

incorporation by reference contains no further editions or amendments; and

c. Hospice services are inclusive except for:
   i. Medical services provided that are not related to the terminal illness;
   ii. Home delivered meals; and
   iii. Hospice services that are provided and covered through Medicare.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective September 22, 1997 (Supp. 97-3).

ARTICLE 3. PREADMISSION SCREENING

R9-28-301. Definitions

A. Common definitions. In addition to definitions contained in A.R.S. Title 36, Chapter 29, and 9 A.A.C. 28, Article 1, for elderly and physically disabled individuals and for individuals with developmental disabilities:

1. "Acute" means an active medical condition having a sudden onset, lasting a short time, and requiring immediate medical intervention.
2. "Chronic" means a medical condition that is always present, occurs periodically, or is marked by a long duration.
3. "Constant/constantly" means at least once a day.
4. "Current" means belonging to the present time.
5. "Disruptive behavior" means inappropriate behavior that interferes with an individual's normal activities or the activities of others and requires intervention to stop or interrupt the behavior.
6. "Frequent/frequently" means weekly to every other day.
7. "Functional assessment" means an evaluation of information about an individual's ability to perform activities related to developmental milestones, activities of daily living, communication, and behaviors.
8. "History" means a medical condition that occurred in the past and may or may not have required treatment and is not now active.
9. "Intervention" means therapeutic treatment, including the use of medication, behavior modification, and physical restraints to control behavior. Intervention may be formal or informal and includes actions taken by friends/family to control the behavior.
10. "Medical assessment" means an evaluation of an individual's medical condition and the individual's need for medical services.
11. "Medical/nursing services and treatments" means specific, ongoing medical, psychiatric, or nursing intervention used actively to resolve or prevent deterioration of a medical condition/diagnosis. Durable medical equipment and activities of daily living assistive devices are not considered to be treatment unless the equipment or devices are used specifically and actively to resolve the existing medical condition.
12. "Occasional/occasionally" means less than once per week.
13. "Physical participation" means active participation, not just being passive or cooperative.
14. "Physically lift" means actively bearing some part of an individual's weight during movement or activity and excludes bracing or guiding activity.
15. "Social worker" means an individual with a baccalaureate or master's degree in social work, rehabilitation, counseling, education, sociology, psychology, or other closely related field, or 2 years of case management related experience.
16. "Special diet" means a diet planned by a dietitian, nutritionist, or nurse such as high fiber, low sodium, or pureed.
17. "Toileting" means the process involved in managing the elimination of urine and feces in an appropriate place.
18. "Vision" means the ability to perceive objects with one's eyes.

B. Elderly and physically disabled. In addition to definitions contained in subsection (A), for elderly and physically disabled individuals only:

1. "Aggression" means physically attacking another, including, but not limited to, throwing objects, punching, biting, pushing, pinching, pulling hair, scratching, and physically threatening behavior.
2. "Bathing" means the process of washing, rinsing, and drying all parts of the body, including an individual's ability to transfer to a tub or shower and to obtain bath water and equipment.
3. "Continence" means the ability to control the discharge of body waste from bladder or bowel.
4. "Dressing" means the physical process of choosing, putting on, securing fasteners, and removing clothing and footwear, including weather appropriate articles but excluding aesthetic concerns such as matching colors. This includes artificial limbs, braces, and other appliances that are needed daily.
5. "Eating" means the process of putting food and fluids by any means into the digestive system.
6. "Elderly" means age 65 or older.
7. "Emotional and cognitive functioning" means an individual's orientation and mental state, as evidenced by overt behaviors.
8. "EPD" means elderly and physically disabled.
9. "Grooming" means the process of tending to one's appearance. This may include, but is not limited to, combing or brushing hair, washing face and hands, shaving, and performing routine nail care, oral hygiene (including denture care), and menstrual care. Grooming does not include aesthetics such as styling hair, skin care, and applying make-up.
10. "Mobility" means the extent of an individual's purposeful movement within a residential environment.
11. "Orientation" means an individual's awareness of self in relation to person, place, and time.
12. "Physically disabled" means the inability to do any substantial gainful activity by reason of any medically determinable physical impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.
13. "Self-injurious behavior" means self-induced, abusive behavior that is directed toward infliction of immediate physical harm to the body.
14. "Sensory" means of or relating to the senses.
15. "Suicidal behavior" means an act or intent to take one's life voluntarily.
16. "Transferring" means an individual's ability to move horizontally or vertically between 2 surfaces within a residential environment, excluding transfer for toileting or bathing.
17. "Wandering" means moving about with no rational purpose and with a tendency to go beyond physical parame-

ters of the environment in a manner that may jeopardize safety.

C. Developmentally disabled. In addition to definitions contained in subsection (A), for only individuals with developmental disabilities:

1. "Aggression" means physically attacking another, including, but not limited to, throwing objects, punching, biting, pushing, pinching, pulling hair, and scratching.
2. "Ambulation" means the ability to walk and includes the quality of the walking and the degree of independence in walking.
3. "Associating time with events and actions" means an individual's ability to associate regular events with specific time frames.
4. "Bathing or showering" means an individual's ability to complete the bathing process including drawing the bath water, washing, rinsing, and drying all parts of the body, and washing the hair.
5. "Caregiver training" means a direct care staff or caregiver trained in special health care procedures normally performed or monitored by a licensed professional, such as a registered nurse. These procedures may include, but are not limited to, ostomy care, positioning for medical necessity, use of adaptive devices, or respiratory services such as suctioning or small volume nebulizer treatments.
6. "Clarity of communication" means an ability to speak in a recognizable language or use a formal symbolic substitution, such as American-Sign Language.
7. "Climbing stairs or ramps" means an individual's ability to move up and down stairs or ramps.
8. "Crawling and standing" means an individual's ability to crawl and stand with or without support.
9. "Developmental milestone" means a measure of an individual's functional abilities including fine and gross motor skills, expressive and receptive language, social and self-help skills, and emotional/affective development.
10. "DD" means developmentally disabled.
11. "Dressing" means the ability to put on and remove articles of clothing and does not include braces nor does it reflect an individual's ability to match colors or choose clothing appropriate for the weather.
12. "Eating/drinking" means the process of putting food and fluid by any means into the digestive system.
13. "Expressive verbal communication" means an individual's ability to communicate thoughts with words or sounds.
14. "Food preparation" means the ability to prepare simple meals.
15. "Hand use" means the ability to use the hands, or hand if an individual has only one hand, or has the use of only one hand.
16. "Limited/occasional" means a small portion of an entire task or assistance required less than daily.
17. "Personal hygiene" means the process of tending to one's appearance. This may include, but is not limited to, combing or brushing hair, washing face and hands, shaving, and performing routine nail care, oral hygiene (including denture care), and menstrual care. Personal hygiene does not include aesthetics such as styling hair, skin care, and applying make-up.
18. "Physical interruption" means immediate hands-on interaction to stop a behavior.
19. "Remembering instructions and demonstrations" means an individual's ability to recall instructions or demonstrations on how to complete specific tasks.
20. "Resistiveness/rebelliousness" means any inappropriate, stubborn, or uncooperative behavior excluding difficulty with processing information or reasonable expression of self-advocacy.
21. "Rolling and sitting" means an individual's ability to roll and sit independently or with the physical support of another person or with a device such as a pillow or specially designed chair.
22. "Running or wandering away" means to leave a situation or environment without either notifying or receiving permission from appropriate individuals as would normally be expected.
23. "Self-injurious behavior" means an individual's repeated behavior that causes injury to the individual and may include, but is not limited to, biting, scratching, putting inappropriate objects into ear, mouth, or nose, repeatedly picking at skin, and head slapping or banging.
24. "Verbal or physical threatening" means any behavior in which an individual uses words, sounds, or action to threaten harm to self, others, or objects.
25. "Wheelchair mobility" means an individual's mobility using a wheelchair and does not include the ability to transfer to the wheelchair.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsection (C) effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed by emergency action, new Section adopted by emergency action, subsection (A) effective June 30, 1995, subsection (B) effective September 1, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days; entire Section filed in the Secretary of State's Office June 30, 1995 (Supp. 95-2). Section repealed by emergency action, new Section adopted again by emergency action with changes effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired June 1, 1996. Section in effect before emergency action restored. Section repealed; new Section adopted effective January 14, 1997 (Supp. 97-1).

R9-28-302. General Provisions

A. To qualify for services described in A.R.S. § 36-2939 under the Arizona Long-term Care System (ALTCS), an individual shall meet the criteria described in Article 4 and shall be determined to require care at the level of a nursing facility or an intermediate care facility for the mentally retarded (ICF-MR) in accordance with the preadmission screening (PAS) process described in this Article.

B. An elderly or physically disabled (EPD) individual shall be assessed using the PAS instrument prescribed in R9-28-303 with the exception of physically disabled children less than 6 years of age who shall be assessed using the age-specific PAS instrument prescribed in R9-28-304 and then referred for physician review in accordance with R9-28-302(J). An individual with developmental disabilities shall be assessed using the PAS instrument prescribed in R9-28-304 with the exception of an individual with developmental disabilities residing in a nursing facility who shall be assessed using the PAS instrument prescribed in R9-28-303. An individual with developmental disabilities less than 6 months of age, shall be assessed using the PAS instrument described in R9-28-304, and then

referred for physician review in accordance with R9-28-302(J).

C. The PAS instrument shall be completed by an Administration assessor who is a registered nurse or a social worker and who has attended a minimum of 24 hours of classroom training for each type of preadmission screening (for EPD individuals and individuals with developmental disabilities). In addition, the Administration shall provide intensive oversight and mentoring for the assessor during the assessor's first 30 days of employment, and ongoing oversight for the assessor's subsequent period of employment.

1. For initial assessments of EPD individuals, the PAS instrument shall be completed by a registered nurse or by a social worker.
2. For initial assessments of individuals with developmental disabilities, the PAS instrument shall be completed by a registered nurse or by a social worker.
3. For initial assessments on hospitalized individuals, the PAS instrument shall be completed by a registered nurse or a team of a registered nurse and social worker.
4. For initial assessments and reassessments of individuals who use a ventilator, the PAS instrument shall be completed by a team composed of a registered nurse and a social worker.

D. Individuals classified as ventilator dependent, as specified in Section 1902 (e)(9) of the Social Security Act, January 1, 1995 (and no future editions), which is incorporated by reference and is on file with the Administration and the Office of the Secretary of State, shall be determined to require care that is provided at a nursing facility or ICF-MR level.

E. Except as provided in subsection (I), an assessor shall conduct the PAS assessment face-to-face with an individual. The assessor shall make reasonable efforts to obtain available medical records. In addition, the assessor may obtain information for the PAS assessment from interviews with the individual, parent, guardian, caregivers, or others familiar with the individual's functional or medical conditions.

F. Except as provided in subsections (L) and (M), the PAS assessment determines an individual's current need for long-term care.

G. Using the information described in subsection (E), and professional judgment based on education, training, and experience, an assessor shall complete the questions on the PAS instrument.

H. After the PAS instrument is completed, a PAS score is calculated. The calculated PAS score is compared to an established threshold score which is based on statistical analyses of the results of pilot studies completed before implementation of the PAS instrument. Except as provided in subsection (I), the threshold score represents the point at which an individual is determined to require the level of care that is provided at a nursing facility or ICF-MR. The scoring methodology and threshold scores are specified in R9-28-303 and R9-28-304.

I. The Administration shall request that an AHCCCS physician consultant review an individual's file if:

1. An EPD individual's PAS score is less than the threshold specified in R9-28-303, but is not less than 56;
2. The PAS score of an individual with developmental disabilities is less than the threshold specified in R9-28-304, but is not less than 38;
3. Notwithstanding the fact that an individual scores below the threshold, the Administration determines in the course of the preadmission screening that it has reasonable cause to believe that the individual's unique functional abilities or medical condition are such that a physician review is necessary to determine whether the items contained in the scored portions of the PAS instrument would indicate that the individual's condition necessitates the level of care provided in a nursing facility or ICF-MR;
4. An individual has a documented diagnosis as seriously mentally ill as defined in A.R.S. § 36-550, and the Administration determines that the individual has no medical diagnosis that in combination with the serious mental illness could necessitate the level of care provided in a nursing facility or ICF-MR. The review can result in a determination of ineligibility only if the physician determines that despite a score at or above the threshold, the individual does not meet the requirements of A.R.S. § 36-2936; or
5. An individual has a documented diagnosis of Autism, autistic-like behaviors or pervasive developmental disorder, if the individual is not eligible by score.

J. Conducting a review.

1. When conducting a review, the physician shall use the information set out in the PAS instrument to determine whether an individual has a nonpsychiatric medical condition or has a developmental disability that, by itself or in combination with other medical conditions, necessitates the level of care which is provided in a nursing facility or intermediate care facility for the mentally retarded. The physician shall review the PAS instrument and available medical records and use his or her professional judgment to determine whether the individual is at risk of institutionalization. At minimum the physician shall consider the following:
   a. ADL dependence; and delays in development;
   b. Continence;
   c. Orientation;
   d. Behavior;
   e. Medical conditions; stability, prognosis;
   f. Medical nursing treatments including skilled monitoring, medications, therapeutic regimens;
   g. Supervision requirements;
   h. Caregiver skill, training requirements; and
   i. Other factors of significance to the individual case.
2. If the physician is unable to determine eligibility from the PAS instrument and available medical records, the physician may conduct a face-to-face review with the individual or contact others familiar with the individual's needs, including primary care physicians or other caregivers. If the reviewing physician recommends overturning the eligibility determination of the initial assessor, the physician shall state the reasons for that decision in the comments section of the instrument.

K. For initial assessments of individuals who are in a hospital or an intensive rehabilitation facility:

1. If the individual's discharge is planned to occur within 7 days, a PAS assessment shall be performed and medical eligibility determined; or
2. If the individual's discharge is not planned to occur within 7 days, a PAS assessment shall not be done and the individual shall be denied for ALTCS. Using the age and disability of the individual to determine which is appropriate, the Administration shall:
   a. Determine whether the individual's income is equal to or less than the Supplemental Security Benefit amount in effect and forward the individual's records to the Department of Economic Security for determining AFDC-related acute care eligibility for AHCCCS, or

b. Evaluate the individual's records for an acute care only determination.

L. Upon request, the Administration shall conduct a PAS assessment to determine whether an individual who has been in a nursing or ICF-MR facility within the 3 months before the month of application, is entitled to receive retroactive benefits for that 3-month period.

M. Upon request, the Administration shall conduct a PAS assessment to determine whether a deceased individual who had been in a nursing facility or ICF-MR during the months covered by the application, would have been eligible to receive ALTCS benefits for those months.

Historical Note

New Section adopted by emergency action, subsection (A) effective June 30, 1995, subsection (B) effective September 1, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days; entire Section filed in the Office of the Secretary of State June 30, 1995 (Supp. 95-2). New Section adopted again by emergency action with changes effective January 2, 1996, pursuant to A.R.S. § 41-1026 (Supp. 96-1). Emergency expired June 1, 1996. New Section adopted effective January 14, 1997 (Supp. 97-1).

R9-28-303. Preadmission Screening for Elderly or Physically Disabled Individuals

A. The PAS instrument for EPD individuals includes 4 major categories: intake information, functional assessment, emotional and cognitive functioning, and medical assessment.

1. The intake information category solicits information on an individual's demographic background. No components of the intake information category are included in the calculated PAS score.
2. The functional assessment category solicits information on an individual's:
   a. Need for assistance with activities of daily living, including bathing, dressing, grooming, eating, mobility, transferring, and toileting in the residential environment or other routine setting;
   b. Communication and sensory skills, including hearing, expressive communication, and vision; and
   c. Continence, including bowel and bladder functioning. A history of transitory incontinence caused by an acute or temporary condition or illness shall not be considered for rating.
3. The emotional and cognitive functioning category solicits information on an individual's:
   a. Orientation to person, place, and time; and
   b. Behavior, including wandering, self-injurious behavior, aggression, suicidal behavior, and disruptive behavior. Some questions in the behavior section refer to intervention and to medical attention. For the purposes of this subsection, medical attention means an examination by a physician, primary care provider, or both, and treatment if necessary.
4. The medical assessment category solicits information on an individual's:
   a. Medical conditions and the medical condition's impact on the individual's ability to perform activities of daily living independently or whether the conditions require medical or nursing treatments;
   b. Medications, treatments, and allergies;
   c. Specific services and treatments that the individual receives or needs and the frequency of those services and treatments; and
   d. A description of the individual's physical characteristics, hospital history, and ventilator dependency.

B. The PAS instrument for EPD individuals, October, 1992, (and no future amendments or editions), is incorporated by reference and is on file with the Administration and the Office of the Secretary of State. When the PAS instrument is completed, the answers selected by the assessor are used to calculate 3 scores: a functional score, a medical score, and a total score.

1. Functional score.
   a. The functional score is based on answers to scored questions in the functional assessment and emotional and cognitive functioning categories. Each answer is assigned a number of points. For each scored question, the number of assigned points is multiplied by a weighted numerical value, resulting in a weighted score for each question. The weighted numerical values are based on statistical analyses of pilot study results and reflect the importance of information on the PAS instrument in predicting whether an individual meets the criteria of A.R.S. § 36-2936.
   b. For EPD individuals, some questions in categories noted below are scored, as indicated in subsection (C), under the Functional Assessment matrices:
      i Sensory skills;
      ii. Medical conditions; and
      iii. Medical services and treatments.
   c. For EPD individuals, all questions in categories noted below are scored, as indicated in subsection (C), under the Functional Assessment matrices:
      i. Activities of daily living;
      ii. Continence;
      iii. Orientation; and
      iv. Behavior.
   d. The sum of the weighted scores equals the functional score. The weighted score per question can range from 0 to 15. The maximum functional score attainable by an individual is 141. There is no minimum functional score that needs to be attained except as prescribed in subsections (B)(3)(c) and (B)(3)(d).
2. Medical score.
   a. The EPD population is divided into 2 groups for purposes of calculating the medical score. The primary distinction between the 2 groups is differences in medical needs.
      i. Group 1 includes individuals diagnosed with paralysis, head trauma, multiple sclerosis, amyotrophic lateral sclerosis, or Parkinson's disease that either impacts the individual's ability to perform activities of daily living independently or requires nursing services or treatments.
      ii. Group 2 includes individuals diagnosed with Alzheimer's disease, dementia, or an organic brain syndrome that either impacts the individual's ability to perform activities of daily living independently or requires nursing services and treatments. If an individual does not meet 1 of the criteria for Group 2, the individual is considered to be in Group 1.
   b. Scoring methodology: Group 1 individuals.
      i. The medical score is based on information obtained from the medical conditions and the services and treatments sections of the PAS instrument.
      ii. Each response to a scored item in the medical assessment category is assigned a certain num-

ber of points, ranging from 0 to 4 points per item.

iii. The sum of the points equals the medical score, with a maximum score of 63. There is no minimum medical score that needs to be attained, except as prescribed in subsection (B)(3)(c).

c. Scoring Methodology: Group 2 individuals.

i. The medical score is based on information obtained from the services and treatments section of the PAS instrument.

ii. Each response to a scored item in the medical assessment category is assigned a number of points, ranging from 0 to 16 points per item.

iii. The sum of the points equals the medical score, with a maximum score of 42. There is no minimum medical score that needs to be attained, except as prescribed in subsection (B)(3)(d).

3. Total score.

a. The sum of an individual's functional and medical scores equals the total score.

b. The total score is compared to an established threshold score. For all EPD individuals, regardless of whether the individual is in Group 1 or in Group 2, the threshold score is 60. Thus, an individual with a total score equal to or greater than 60 is deemed to require care that is provided at the nursing facility or ICF-MR level.

c. If an individual is in Group 1 and has a total score less than 60, a functional score equal to or greater than 30 and a medical score equal to or greater than 13, the individual is deemed to require care that is provided at the nursing facility or ICF-MR level.

d. If an individual is in Group 2 and has a total score less than 60:

i. A functional score equal to or greater than 30 and a weighted score from the orientation section equal to or greater than 5, the individual is deemed to require care that is provided at the nursing facility or ICF-MR level; or

ii. A functional score equal to or greater than 30 and the individual is assigned at least 2 points for any 1 question in the behavior section, the individual is deemed to require care that is provided at the nursing facility or ICF-MR level.

C. The following tables represent the number of points available and the weight for each scored question.

[1] The lowest value in the range of points available per question in the functional assessment category indicates minimal or no impairment and, conversely, the highest value indicates severe impairment.

Functional Assessment	**# of Points Available Per Question[1] (P)**	**Weight (W)**	**Range of Possible Weighted Score per Question (P)x(W)**
Activities of Daily Living Section			
Bathing, Dressing, Grooming, Mobility, Toileting	0-5	3.00	0-15
Eating	0-6	2.50	0-15
Transfer	0-4	3.75	0-15
Continence Section			
Bowel	0-2	0	0
	3	.167	.5
Bladder	0-4	0.50	0-2
Sensory Section			
Vision	0-1	0	0
	2	1.75	3.5
	3	1.167	3.5
Orientation Section			
Person, Place, Time	0-3	1.00	0-3
Emotional/Cognitive Behavior Section			
Aggression, Self-injurious, Suicidal, Wandering	0-3	1.00	0-3
Disruptive	0-3	3.00	0-9

Medical Assessment **Group 1**	**# of Points Available Per Question[1] (P)**	**Weight (W)**	**Range of Possible Weighted Score Per Question (P)x(W)**
Medical Conditions Section			
Paralysis/Sclerosis	0-1	3.00	0 - 3
Alzheimer's/OBS/ Dementia	0-1	3.50	0 - 3.5
Services and Treatments Section			
Physical Therapy, Occupational Therapy, Speech Therapy	0-1	0.50	0 - .5
Suctioning, Oxygen, Small Volume Nebulizer, Tracheostomy Care, Postural Drainage, Respiratory Therapy	0-1	1.50	0 or 1.5
Drug Regulation	0-1	2.00	0 or 2

Decubitus Care, Wound Care, Ostomy Care, Feedings-Tube and/or Parenteral, Catheter Care, Other Ostomy Care, Dialysis, Fluid Intake/Output	0-1	3.00	0 or 3
Teaching/Training Program, Bowel/ Bladder Program, Range of Motion, Other Rehabilitative Nursing, Restraints	0-1	4.00	0 or 4
Medical Assessment Group 2	**# of Points Available per Question (P)**	**Weight (W)**	**Range of Possible Weighted Score Per Question**[1]
Drug Regulation	0-1	2.00	0 or 2
Teaching/Training Program, Bowel/ Bladder Program, Range of Motion, Other Rehabilitative Nursing	0-1	6.00	0 or 6
Restraints (Physical/Chemical)	0-1	16.00	0 or 16

[1]. The lowest value in the range of points available per question in the medical assessment category, 0, indicates that the individual does not have the medical condition or does not need or receive the medical or nursing service treatment. Conversely, the highest value, 1, indicates that the individual does have the medical condition or does need or receive the medical or nursing service or treatment.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective July 13, 1992 (Supp. 92-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed by emergency action, new Section adopted by emergency action effective June 30, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 95-2). Section repealed by emergency action, new Section adopted again by emergency action effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired June 1, 1996. Section in effect before emergency action restored. Section repealed; new Section adopted effective January 14, 1997 (Supp. 97-1).

R9-28-304. Preadmission Screening for Individuals with Developmental Disabilities

A. The Administration shall conduct preadmission screening of individuals with developmental disabilities using 1 of 4 PAS instruments specifically designed to assess individuals in the following age groups: individuals 12 years of age and older; children 6 to 11 years of age; children 3 to 5 years of age; and children less than 3 years of age.

B. The PAS instruments for individuals with developmental disabilities include 3 major categories: intake information, functional assessment, and medical assessment.

1. The intake information category solicits information on an individual's demographic background. No components of the intake information category are scored.
2. The functional assessment category differs by age group, as indicated in subsections (B)(2)(a) through (B)(2)(e) below:
   a. For individuals 12 years of age and older, the functional assessment category solicits information on an individual's:
      i. Need for assistance with independent living skills, including hand use, ambulation, wheelchair mobility, transfer, eating/drinking, dressing, personal hygiene, bathing or showering, food preparation, community mobility, and toileting;
      ii. Communication skills and cognitive abilities, including expressive verbal communication, clarity of communication, associating time with events and actions, and remembering instructions and demonstrations; and
      iii. Behavior, including aggression, verbal or physical threatening behavior, self-injurious behavior, and resistive/rebellious behavior.
   b. For individuals 6 through 11 years of age, the functional assessment category solicits information on an individual's:
      i. Need for assistance with independent living skills, including rolling and sitting, crawling and standing, ambulation, climbing stairs or ramps, wheelchair mobility, dressing, personal hygiene, bathing or showering, toileting, level of bladder control, and orientation to familiar settings;
      ii. Communication, including expressive verbal communication and clarity of communication; and
      iii. Behavior, including aggression, verbal or physical threatening behavior, self-injurious behavior, running or wandering away, and disruptive behavior.
   c. For individuals 3 through 5 years of age, the functional assessment category solicits information on an individual's:
      i. Status with respect to a series of developmental milestones, including 50 factors that measure an individual's degree of functional growth;
      ii. Need for assistance with independent living skills, including toileting and dressing, and the individual's orientation to familiar settings;
      iii. Communication, including clarity of communication; and
      iv. Behavior, including aggression, verbal or physical threatening behavior, and self-injurious behavior.
   d. For individuals 6 months of age and up to 3 years of age, the functional assessment category solicits information on the individual's degree of functional growth using age specific factors.
   e. For individuals less than 6 months of age, a functional assessment is not completed.
3. Function assessment scoring.
   a. For individuals 12 years of age and older, all questions in the behavior section are scored, and some

questions in the independent living skills, communication skills, and cognitive abilities sections are scored, as indicated in subsection (D), under the Functional Assessment matrix.

b. For individuals 6 through 11 years of age, all questions in the communication section are scored, and some questions in the independent living skills and behavior sections are scored, as indicated in subsection (D), under the Functional Assessment matrix.

c. For individuals 3 through 5 years of age, all questions in the developmental milestones and behavior section are scored, and some questions in the independent living skills are scored, as indicated in subsection (D), under the Functional Assessment matrix.

d. For individuals 6 months of age up to 3 years of age, all questions regarding specific factors measuring the degree of functional growth are scored, as indicated in subsection (D), under the Functional Assessment matrix.

4. The medical assessment category solicits information on an individual's:

a. Medical conditions;

b. Specific services and treatments the individual receives or needs and the frequency of those services and treatments;

c. Current medications and treatments, medical stability, sensory functioning and physical measurements; and

d. Current placement, ventilator dependency and DD status of the individual, as determined by the Department of Economic Security.

5. Medical assessment scoring.

a. For individuals 12 years of age and older, some questions in the medical conditions section are scored, as indicated in subsection (D), under the Medical Assessment matrix.

b. For individuals 6 years through 11 years of age, some questions in the medical conditions section are scored, as indicated in subsection (D), under the Medical Assessment matrix.

c. For individuals 3 years of age up to 6 years of age, some questions in the medical conditions and medical stability sections are scored, as indicated in subsection (D), under the Medical Assessment matrix.

d. For individuals 6 months of age up to 3 years of age, some questions in the medical conditions, services and treatments, and medical stability sections are scored, as indicated in subsection (D), under the Medical Assessment matrix.

e. For individuals less than 6 months of age, a medical assessment is completed; however, no questions are scored. These individuals are referred for physician review.

C. The PAS instruments for individuals with developmental disabilities, August, 1995, (and no future editions or amendments), are incorporated by reference and are on file with the Administration and the Office of the Secretary of State. When the PAS instrument is completed, the answers selected by the assessor are used to calculate 3 scores: a functional score, a medical score, and a total score.

1. Functional score.

a. The functional score is based on answers to scored questions in the functional assessment category. Each answer is assigned a number of points. For each scored question, the number of points is multiplied by a weighted numerical value resulting in a weighted score for each question. The weighted numerical values are based on statistical analyses of the results of pilot studies completed before implementation of the PAS instrument and reflect the importance of information on that instrument in predicting whether an individual meets the criteria of A.R.S. § 36-2936.

b. The sum of the weighted scores equals the functional score. The range of weighted score per question and maximum functional score for each age group is presented below:

AGE GROUP	RANGE FOR WEIGHTED SCORE PER QUESTION	MAXIMUM FUNCTIONAL SCORE ATTAINABLE
12+	0 - 11.2	124.1
6-11	0 - 24.0	112.5
3-5	0 - 15.6	78.2
0-2	0 - 1.4	70.0

c. There is no minimum functional score that needs to be attained.

2. Medical score.

a. The medical score is based on information obtained in the medical assessment category. Each response to a scored item is assigned a number of points. The sum of the points equals the medical score. The range of points per item and the maximum medical score attainable by an individual is presented below:

AGE GROUP	RANGE OF POINTS PER ITEM	MAXIMUM MEDICAL SCORE ATTAINABLE
12+	0 - 20.6	21.4
6-11	0 - 2.5	5.0
3-5	0 - 14.8	23.0
0-2	0 - 7.0	44.3

b. There is no minimum medical score that needs to be attained.

3. Total score.

a. The sum of an individual's functional and medical scores equals the total score.

b. The total score is compared to an established threshold score. For all individuals with developmental disabilities, the threshold score is 40. Thus, an individual with a total score equal to or greater than 40 is deemed to require care that is provided at the nursing facility or ICF-MR level.

D. The following tables represent the number of points available and the weight for each scored question.

AGE GROUP 12 AND OLDER **Functional Assessment**	**# of Points Available Per Question[1] (P)**	**Weight (W)**	**Range of Possible Weighted Score Per Question (P) x (W)**
Independent Living Skills Section			
Hand Use, Food Preparation	0-3	3.50	0-10.5
Ambulation, Toileting, Eating, Dressing, Personal Hygiene	0-4	2.80	0-11.2
Communicative Skills and Cognitive Abilities Section			
Associating Time, Remembering Instructions	0-3	0.50	0 - 1.5
Behavior Section			
Aggression, Threatening, Self Injurious	0-4	2.80	0-11.2
Resistive	0-3	3.50	0-10.5

[1]The lowest value in the range of points available per question in the functional assessment category indicates minimal to no impairment and, conversely, the highest value indicates severe impairment.

AGE GROUP 12 AND OLDER **Medical Assessment**	**# of Points Available Per Question[1] (P)**	**Weight (W)**	**Range of Possible Weighted Score Per Question (P) x (W)**
Medical Conditions Section			
Cerebral Palsy, Epilepsy	0-1	0.40	0-.4
Moderate, Severe, Profound Mental Retardation	0-1	20.60	0-20.6

[1]The lowest value in the range of points available per question in the medical assessment category, 0, indicates that the individual does not have the medical condition or does not need or receive the medical or nursing service or treatment. Conversely, the highest value, 1, indicates that the individual does have the medical condition or does need or receive the medical or nursing service or treatment.

AGE GROUP 6-11 **Functional Assessment**	**# of Points Available Per Question[1] (P)**	**Weight (W)**	**Range of Possible Weighted Score Per Question (P) x (W)**
Independent Living Skills Section			
Climbing Stairs, Wheelchair Mobility, Bladder Control	0-3	1.875	0-5.625
Ambulation, Dressing, Bathing, Toileting	0-4	1.50	0-6
Crawling/Standing	0-5	1.25	0-6.25
Rolling/Sitting	0-8	0.833	0-6.66
Communication Section			
Clarity	0-4	1.50	0-6
Expressive Communication	0-5	1.25	0-6.25
Behavior Section			
Wandering	0-4	6.00	0-24
Disruptive	0-3	7.50	0-22.5

[1]The lowest value in the range of points available per question in the functional assessment category indicates minimal to no impairment and, conversely, the highest value indicates severe impairment.

AGE GROUP 6 - 11 **Medical Assessment**	**# of Points Available Per Question[1] (P)**	**Weight (W)**	**Range of Possible Weighted Score Per Question (P) x (W)**
Medical Conditions Section			
Cerebral Palsy, Epilepsy	0-1	2.50	0-2.5

[1]The lowest value in the range of points available per question in the medical assessment category, 0, indicates that the individual does not have the medical condition or does not need or receive the medical or nursing service or treatment. Conversely, the highest value, 1, indicates that the individual does have the medical condition or does need or receive the medical or nursing service or treatment.

AGE GROUP 3-5 Functional Assessment	# of Points Available Per Question[1] (P)	Weight (W)	Range of Possible Weighted Score Per Question (P) x (W)
Developmental Milestones Section			
Factors Measuring an Individual's Degree of Functional Growth	0-1	0.70	0-.7
Independent Living Skills Section			
Toileting, Dressing	0-4	3.90	0-15.6
Behavior Section			
Aggression, Threatening, Self Injurious	0-4	1.00	0-4

[1]The lowest value in the range of points available per question in the functional assessment category indicates minimal to no impairment and, conversely, the highest value indicates severe impairment.

AGE GROUP 3 - 5 Medical Assessment	# of Points Available Per Question[1] (P)	Weight (W)	Range of Possible Weighted Score Per Question (P) x (W)
Medical Conditions Section			
Moderate, Severe, Profound Mental Retardation	0-1	14.80	0-14.8
Medical Stability Section			
Direct Caregiver Required, Special Diet	0-1	4.10	0-4.1

[1]The lowest value in the range of points available per question in the medical assessment category, 0, indicates that the individual does not have the medical condition or does not need or receive the medical or nursing service or treatment. Conversely, the highest value, 1, indicates that the individual does have the medical condition or does need or receive the medical or nursing service or treatment.

AGE GROUP 0-2 Functional Assessment	# of Points Available Per Question[1] (P)	Weight (W)	Range of Possible Weighted Score Per Question (P) x (W)
Developmental Milestones Section			
Factors Measuring an Individual's Degree of Functional Growth	0-1	1.40	0-1.4

[1]The lowest value in the range of points available per question in the functional assessment category indicates minimal to no impairment and, conversely, the highest value indicates severe impairment.

AGE GROUP 0-2 Medical Assessment	# of Points Available Per Question[2]	Weight	Range of Possible Weighted Score Per Question (P) x (W)
Services and Treatments Section			
Non-Bladder/Bowel Ostomy, Tube Feeding, Oxygen	0-1	6.10	0-6.1
Medical Conditions Section			
Any Mental Retardation, Epilepsy, Cerebral Palsy	0-1	7.00	0-7
Medical Stability Section			
Trained Direct Caregiver, Special Diet or a Minimum of 2 Hospitalizations	0-1	5.00	0-5

[2]The lowest value in the range of points available per question in the medical assessment category, 0, indicates that the individual does not have the medical condition or does not need or receive the medical or nursing service or treatment. Conversely, the highest value, 1, indicates that the individual does have the medical condition or does need or receive the medical or nursing service or treatment.

Historical Note

New Section adopted by emergency action, subsection (A) effective June 30, 1995, subsection (B) effective September 1, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days; entire Section filed as an emergency rule with the Secretary of State's Office June 30, 1995 (Supp. 95-2). New Section adopted again by emergency action with changes effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired. New Section adopted effective January 14, 1997 (Supp. 97-1).

R9-28-305. Reassessments

A. An Administration assessor shall reassess each ALTCS member to determine continued need for ALTCS services. The assessor shall base the determination of continued qualifica-

tion for ALTCS services on the same criteria used for the initial preadmission screening as prescribed in R9-28-302, R9-28-303, and R9-28-304.

B. One or more of the individuals described in R9-28-302(C) shall conduct each reassessment and may refer the assessment for physician review.

C. Reassessment by the Administration shall occur as follows:
1. Annually, except in the following circumstances:
   a. EPD individuals 80 years of age and older who have been ALTCS eligible for 2 consecutive years shall be reassessed every other year;
   b. EPD individuals diagnosed with Alzheimer's disease, dementia, or an organic brain syndrome who have been ALTCS eligible for 2 consecutive years shall be reassessed every other year;
   c. EPD individuals who have been eligible for 2 or more consecutive years and have had a SNF-2 level of care on their last 2 PAS assessments shall be reassessed every other year;
   d. EPD individuals who have been eligible for 3 or more consecutive years and have been continuously institutionalized for 3 or more years shall be reassessed every other year;
   e. DD individuals with severe or profound mental retardation who have been eligible for 2 or more consecutive years shall be reassessed every other year; and
   f. The Administration identifies other EPD and DD population groups within the ALTCS program for which a reassessment period greater than 1 year is appropriate.
2. In connection with routine audit of the preadmission screening by the Administration in which errors affecting eligibility are discovered.
3. In connection with an audit of the preadmission screening requested by a nursing facility, program contractor, case manager, or other party where the Administration has determined that continued eligibility is uncertain due to substantial evidence of a change in the member's circumstances or error in the preadmission screening; and
4. At the request of the Administration's physician consultant.

Historical Note
Section adopted by emergency action effective June 30, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 95-2). Section adopted again by emergency action effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired. New Section adopted effective January 14, 1997 (Supp. 97-1).

Editor's Note: The following Section was adopted and amended under an exemption from the rulemaking provisions of the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6, §§ 1001 et seq.). Exemption from A.R.S. Title 41, Chapter 6 means that the Governor's Regulatory Review Council did not review these rules, AHCCCS was not required to hold public hearings on these rules, and the Attorney General has not certified these rules.

R9-28-306. Transitional Program for Elderly and Physically Disabled and Developmentally Disabled Members and Eligible Persons

A. Effective September 1, 1995, a transitional program is established for members and eligible persons meeting the criteria set forth in this Section. The ALTCS transitional program serves members and eligible persons enrolled in the ALTCS program who, at the time of reassessment as described in R9-28-305, are found to no longer meet the threshold specified in R9-28-303 for the elderly and physically disabled or in R9-28-304(B) for the developmentally disabled. Members and eligible persons qualifying for the transitional program may receive appropriate home- and community-based services.

B. Developmentally disabled members and eligible persons who are otherwise eligible for ALTCS shall be transferred from the ALTCS program to the ALTCS transitional program if, at the time of a reassessment conducted subsequent to September 1, 1995, the total preadmission score is less than the threshold described in R9-28-304(B) but is not less than 30, or the member or eligible person is diagnosed with moderate, severe, or profound mental retardation.

C. Elderly and physically disabled members and eligible persons who are otherwise eligible for ALTCS shall be transferred from the ALTCS program to the ALTCS transitional program if, at the time of a reassessment conducted subsequent to September 1, 1995, the preadmission screening score is less than the threshold described in R9-28-303 but the member or eligible person meets one or more of the following criteria:
1. Has a score of two or more on three of the following five activities for daily living: eating, dressing, bathing, toileting, and transferring;
2. Has a diagnosis of Alzheimer's disease, organic brain syndrome, dementia, Parkinson's disease, or head trauma which impacts activities of daily living;
3. Has a score of two or more on any of the items in the emotional and cognitive functioning category.

D. Members and eligible persons qualifying for the transitional program shall be reassessed annually to determine if they continue to meet the criteria specified in subsections (B) and (C).

E. For members and eligible persons residing in a nursing facility (NF) or an intermediate care facility for the mentally retarded (ICF-MR), the program contractor or the Administration has up to 90 days, from the effective date of the member's or eligible person's eligibility for the transitional program, to move the member or eligible person to an approved home- and community-based setting.

F. Members and eligible persons shall continue to receive all medically necessary covered services as specified in Article 2.

G. For members and eligible persons whose condition worsens to the extent that NF or ICF-MR services are medically necessary on a temporary basis, the program contractor or the Administration may place the member or eligible person in a NF or ICF-MR for up to 90 days at any one admission.

H. For members requiring medically necessary NF or ICF-MR services for longer than 90 days, the program contractor shall request the Administration to conduct a reassessment.

Historical Note
Adopted effective September 1, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1994, Ch. 322, § 21; filed with the Office of the Secretary of State June 29, 1995 (Supp. 95-3).

ARTICLE 4. ELIGIBILITY AND ENROLLMENT

R9-28-401. General

A. Application for ALTCS coverage.
1. The Administration shall provide a person the opportunity to apply for ALTCS without delay.
2. A person may be accompanied, assisted, or represented by another in the application process.
3. To apply for ALTCS, a person shall submit a written application to an ALTCS eligibility office.

a. The application shall contain the applicant's name and address.
b. The application may be submitted by the applicant's representative.
c. The application shall be signed by the person requesting ALTCS coverage or by a representative.
d. A witness shall also sign an application if an applicant signs an application with a mark.
e. The date of application is the date the application is received at any ALTCS eligibility office.

4. Except when there is an emergency beyond the Administration's control, the Administration shall not delay the eligibility determination beyond the following timeframes when information necessary to make the determination has been provided or obtained:
a. 90 days for an applicant applying on the basis of disability; or
b. 45 days for all other applicants.

5. The applicant or representative who files the ALTCS application may withdraw the application for ALTCS coverage either orally or in writing to the ALTCS eligibility office where the application was filed. An applicant withdrawing an ALTCS application shall receive a denial notice under subsection (H).

B. Conditions of ALTCS eligibility. Except for persons identified in subsection (C), a person shall be approved for ALTCS if all conditions of eligibility for 1 of the ALTCS coverage groups listed in R9-28-402(B) are met. The conditions of eligibility are:
1. Categorical requirements specified in R9-28-402;
2. Citizenship and alien status specified in R9-28-404;
3. SSN specified in R9-28-405;
4. Living arrangements specified in R9-28-406;
5. Resources specified in R9-28-407;
6. Income specified in R9-28-408;
7. Transfers specified in R9-28-409;
8. A legally authorized person shall assign rights to the Administration for medical support and for payment of medical care from any 1st-and 3rd-parties and shall cooperate by:
a. Establishing paternity and obtaining medical support and payments, except for poverty-level women specified in A.A.C. R9-22-1422(C), unless the person establishes good cause for not cooperating; and
b. Identifying and providing information to assist the Administration in pursuing 1st-and 3rd-parties who may be liable to pay for care and services unless the person establishes good cause for not cooperating;
9. A person shall take all necessary steps to obtain annuity, pension, retirement, and disability benefits for which a person may be entitled unless the person establishes good cause for not doing so;
10. State residency specified in R9-28-403; and
11. Medical eligibility specified in Article 3.

C. Persons eligible for Title IV-E, Title XVI, or 42 U.S.C. 1396u-1. To be determined eligible for ALTCS, a person eligible for Title IV-E (Foster Care/Adoption Subsidy), Title XVI of the Social Security Act (Supplementary Security Income), or 42 U.S.C. 1396u-1 shall provide information to determine:
1. Medical eligibility specified in Article 3;
2. Post-eligibility treatment of income specified in R9-28-408;
3. Trusts in accordance with federal and state law; and
4. Transfer of property specified in R9-28-409.

D. Verification. If requested by the Administration, a person shall provide information and documentation to verify the following criteria or shall authorize the Administration to verify the following criteria:
1. Categorical requirements specified in R9-28-402,
2. SSN specified in R9-28-405,
3. Living arrangements specified in R9-28-406,
4. Resources specified in R9-28-407,
5. Transfers of assets specified in R9-28-409,
6. Income specified in R9-28-408,
7. Citizenship and alien status specified in R9-28-404,
8. 1st-and 3rd-party liability specified in subsection (B)(8),
9. Application for potential benefits specified in subsection (B)(9),
10. State residency specified in R9-28-403,
11. Medical conditions specified in Article 3, and
12. Other individual circumstances necessary to determine a person's eligibility and post-eligibility treatment of income (share-of-cost).

E. Documentation of the eligibility decision. The ALTCS eligibility interviewer shall include facts in a person's case record to support the decision on the person's application.

F. Eligibility effective date. Eligibility shall be effective the 1st day of the month that all eligibility requirements are met but no earlier than the prior quarter period specified in subsection (G).

G. Prior quarter.
1. Prior quarter period. Eligibility for ALTCS medical assistance or ALTCS acute care services shall be no earlier than 3 months prior to the month of application.
2. Prior quarter eligibility.
a. Eligibility for prior quarter coverage is determined for each individual month in the prior quarter period on a month-by-month basis and may be for 1, 2, or 3 months of the prior quarter period.
b. A person shall meet all eligibility criteria for ALTCS, including criteria specified in subsection (G)(2)(d) or ALTCS acute care for each approved month.
c. Eligibility may vary between ALTCS coverage and ALTCS acute care from month-to-month during the prior quarter period.
d. Only a person who resided in an NF and who is determined medically eligible under Article 3 during a prior quarter month may be eligible for ALTCS coverage for that prior quarter month.
e. A person who received home and community-based services, defined in Article 2, is not eligible for ALTCS coverage during a prior quarter month but may be eligible for ALTCS acute care services.
f. A person who does not meet the requirement in subsection (G)(2)(d) may be eligible for ALTCS acute care coverage.

H. Notice. The Administration shall send a person a written notice of the decision regarding the person's application. The notice shall include a statement of the action and an explanation of the person's hearing rights specified in Article 8 and:
1. If the applicant's eligibility is approved, the notice shall contain:
a. The effective date of eligibility; and
b. Post-eligibility treatment of income (share-of-cost) information (the amount the person shall pay toward the cost of care).
2. If the applicant's eligibility is denied, the notice shall contain:
a. The effective date of the denial;

b. A statement detailing the reason for the person's denial, including specific financial calculations and the financial eligibility standard if applicable; and
c. The legal authority supporting the decision.

I. Confidentiality. The Administration shall maintain the confidentiality of a person's record and shall not disclose the person's financial, medical, or other privacy interests except specified in A.A.C. R9-22-512.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-402. Categorical Requirements and Coverage Groups

A. Categorical requirements. As a condition of ALTCS eligibility, a person shall meet 1 of the following categorical requirements in this Section under 42 CFR 435, Subpart F, August 18, 1994, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
1. Aged.
   a. "Aged" means a person who is 65 years of age or older.
   b. A person is considered to be age 65 on the day before the anniversary of birth.
   c. Age shall be verified under 20 CFR 404.715 and 20 CFR 404.716, June 7, 1978, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
2. Blind. Blindness shall be determined by the DES Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(2), October 31, 1994, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
3. Disabled.
   a. For a person who is age 18 or older, disability shall be determined by the DES Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E), October 31, 1994, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
   b. A person under age 18 is considered to be disabled for ALTCS if the person is determined medically eligible specified in Article 3.
4. Child. A child is a person defined in A.A.C. R9-22-1401(B).
5. Pregnant.
   a. Pregnancy shall be medically verified by 1 of the following licensed health care professionals:
      i. Licensed physician;
      ii. Certified physician's assistant;
      iii. Certified nurse practitioner;
      iv. Licensed midwife; or
      v. Licensed registered nurse, under the direction of a licensed physician.
   b. Written verification of pregnancy shall include the expected date of delivery.
6. A specified relative who is the caretaker relative of a deprived child specified in A.A.C. R9-22-1406(B) or (G) and R9-22-1418.

B. ALTCS coverage groups. In addition to other requirements in this Article, a person shall meet ALTCS eligibility criteria in 1 of the following coverage groups:
1. A coverage group described in A.R.S. § 36-2901(4)(b).
2. The 211 coverage group specified in 42 CFR 435.211. A person in the 211 coverage group is medically eligible as specified in Article 3 and would be eligible for SSI cash assistance or the 1931 group specified in R9-22-1406 if the person is not in a medical institution.
3. The 236 coverage group specified in 42 CFR 435.236. A person in the 236 coverage group is medically eligible as specified in Article 3 and the person resides in a medical institution.
4. The 217 coverage group specified in 42 CFR 435.217. A person in the 217 coverage group is medically eligible as specified in Article 3 and the person resides in a home and community-based setting described in R9-28-406(A)(2).

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Repealed effective November 4, 1998 (Supp. 98-4). New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-403. State Residency

As a condition of eligibility, a person shall be a resident of Arizona as specified in 42 CFR 435.403, December 21, 1990, incorporated by reference and on file with the Administration and Secretary of State. This incorporation contains no future editions or amendments.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Amended effective July 13, 1992 (Supp. 92-3). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-404. Citizenship and Qualified Alien Status

As a condition of eligibility, a person shall be:
1. A citizen of the United States;
2. A qualified alien specified in 8 U.S.C. 1641 and A.R.S. § 36-2903.03, to the extent consistent with federal law; or
3. A nonqualified alien who received ALTCS services on or before August 21, 1996, as specified in Laws 1997, Ch. 300, § 70.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-405. Social Security Enumeration

As a condition of eligibility, a person shall furnish an SSN, as specified in 42 CFR 435.910 and 435.920.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989

(Supp. 89-2). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-406. ALTCS Living Arrangements

A. Long-term care living arrangements. A person may be eligible for ALTCS services, under Article 2, while living in 1 of the following settings:
1. Institutional settings:
   a. A nursing facility (NF) defined in 42 U.S.C. 1396r(a),
   b. An institution for mental disease (IMD) for a person who is either under age 21 or age 65 or older,
   c. An ICF-MR for a person with developmental disabilities,
   d. A hospice (free-standing, hospital, or nursing facility subcontracted beds) defined in A.R.S. § 36-401; or
2. Home and community-based services (HCBS) settings:
   a. A person's home defined in R9-28-101(B), or
   b. Alternative HCBS settings defined in R9-28-101(B).

B. ALTCS acute care living arrangements. A person applying for or receiving ALTCS coverage shall be eligible for only ALTCS acute care coverage in the following living arrangements, settings, or locations:
1. The income limit is 300% of the FBR for a person meeting the requirements of the 236 coverage group specified in R9-28-402(B) and who resides in 1 of the following settings:
   a. A noncertified medical facility, or
   b. A medical facility that is registered with AHCCCS but does not have a contract with an ALTCS program contractor, or
   c. A location outside of Arizona if the person is temporarily absent from Arizona.
2. The income limit is 100% of the FBR for a person who does not meet the requirements of the 217 or 236 coverage groups specified in R9-28-402(B) and who resides in 1 of the following settings:
   a. At home or in an alternative HCBS setting if a person refuses HCBS service;
   b. A room in an assisted living center, or a licensed assisted living home or center which is not registered with AHCCCS;
   c. At home or in an alternative HCBS setting if the person requests but does not receive HCBS due to the federal limit on HCBS that can be provided by the state;
   d. A room-and-board home;
   e. An unlicensed care home;
   f. An EPD disabled residence in a Level III Behavioral Health Facility; or
   g. A commercially-operated facility that provides some HCBS.

C. Inmate of a public institution. An inmate of a public institution is not eligible for the ALTCS program if federal financial participation (FFP) is not available.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-407. Resource Criteria for Eligibility

A. The following Medicaid-eligible persons shall be deemed to meet the resource requirements for ALTCS eligibility unless ineligible due to federal and state laws regarding trusts.
1. A person receiving Supplemental Security Income (SSI);
2. A person receiving Title IV-E Foster Care Maintenance payment;
3. A person receiving a Title IV-E Adoption Assistance; or
4. A person described in Section 1931 of the Social Security Act 42 U.S.C. 1396u-1, July 1, 1997, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. Except as provided in subsection (D)(1), if a person's Medicaid eligibility is most closely related to SSI and is not included in subsection (A), the Administration shall determine eligibility using resource criteria in 42 U.S.C. 1382(a)(2)(B) and (b), August 15, 1994, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

C. Except as provided in subsections (D)(1) and (2), if a person's Medicaid eligibility is most closely related to 42 U.S.C. 1396u-1 and is not included in subsection (A), the Administration shall use the resource criteria to determine eligibility specified in A.A.C. R9-22-1426 through R9-22-1427.

D. The Administration permits exceptions to the resource criteria for a person identified in subsections (B) and (C):
1. Resources of a responsible relative (spouse or parent) are disregarded beginning the 1st day in the month the person is institutionalized.
2. The value of household goods and personal effects is excluded.
3. The value of oil, timber, and mineral rights is excluded.
4. The value of all of the following shall be disregarded:
   a. Term insurance;
   b. Burial insurance;
   c. Assets that a person has irrevocably assigned to fund the expense of a burial;
   d. The cash value of all life insurance if the face value does not exceed $1,500 total per insured person and the policy has not been assigned to fund a pre-need burial plan or declaratively designated as a burial fund;
   e. The value of any burial space held for the purpose of providing a place for the burial of the person, a spouse, or any other member of the immediate family;
   f. At the time of eligibility determination, $1,500 of the equity value of an asset declaratively designated as a burial fund or a revocable burial arrangement if there is no irrevocable burial arrangement; and
   g. If the person remains continuously eligible, all appreciation in the value of the assets in subsection (D)(4)(f) will be disregarded;
5. For an institutionalized spouse, a resource disregard is allowed under 42 U.S.C. 1396r-5(h)(1), September 30, 1989, and 42 U.S.C. 1396r-5(c), September 30, 1989, incorporated by reference and on file with the Administration and the Secretary of State. These incorporations by reference contain no future editions or amendments.
6. Trusts are evaluated in accordance with federal and state laws to determine eligibility.

E. A person is not eligible for long-term care services if countable resources exceed the following limitations:
1. For a SSI-related person identified in subsection (B), the limit is $2,000 or $3,000 per couple under 20 CFR 416.1205, September 26, 1985, incorporated by reference and on file with the Administration and the Secre-

tary of State. This incorporation by reference contains no future editions or amendments;

2. For a person in subsection (C), the limit is $2,000 as specified in A.A.C. R9-22-1427; and
3. For a person eligible for S.O.B.R.A., there is no resource limit specified in A.A.C. R9-22-1406(I) and (J).

F. A person shall provide information and verification necessary to determine the countable value of resources.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-408. Income Criteria for Eligibility

A. The following Medicaid-eligible persons shall be deemed to meet the income requirements for eligibility unless ineligible due to a trust in accordance with federal and state law.

1. A person receiving Supplemental Security Income (SSI);
2. A person receiving Title IV-E Foster Care Maintenance Payments;
3. A person receiving Title IV-E Adoption Assistance; or
4. A person described in Section 1931 of the Social Security Act 42 U.S.C. 1396u-1, July 1, 1997, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. Except as provided in subsection (D), if a person's Medicaid eligibility is most closely related to SSI and the person is not included in subsection (A), the Administration shall use the methodology in 42 U.S.C. 1382(a), August 15, 1994, incorporated by reference and on file with the Administration and the Secretary of State, to determine eligibility. This incorporation by reference contains no future editions or amendments.

C. Except as provided in subsection (D), if a person's Medicaid eligibility is most closely related to 42 U.S.C. 1396u-1 and the person is not included in subsection (A), the methodology in A.A.C. R9-22-1428 through R9-22-1430 and 42 U.S.C. 1396a(a)(17)(D) is used to determine eligibility. 42 U.S.C. 1396u-1, July 1, 1997, and 42 U.S.C. 1396a(a)(17)(D), November 5, 1990, are incorporated by reference and on file with the Administration and the Secretary of State. These incorporations by reference contain no future editions or amendments.

D. The following are income exceptions.

1. The following are income exceptions for a person identified in subsections (B) and (C):
   a. Disbursements from a trust are considered in accordance with federal and state law;
   b. Income types excluded by 42 U.S.C. 1382a(b), August 22, 1996, incorporated by reference and on file with the Administration and the Secretary of State and not including any future editions or amendments, for determining net income are also excluded in determining gross income to determine eligibility;
   c. Income of a responsible relative (parent or spouse) is counted as part of income in accordance with 42 CFR 435.602, except that the income of a responsible relative is disregarded the month the person is institutionalized. 42 CFR 435.602, August 22, 1994, is incorporated by reference and on file with the Administration and the Secretary of State and contains no future editions or amendments; and
   d. For a person defined in 42 U.S.C. 1396r-5(h)(1) income is calculated for the institutionalized spouse in accordance with 42 U.S.C. 1396r-5(b), October 1, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
2. For a person identified in subsection (B), in-kind support and maintenance, specified in 42 U.S.C. 1382a(a)(2)(A), are excluded for both net and gross income tests.
3. The following are income exceptions to SSI methodology for the net income test:
   a. For a person living with a spouse, the computation rules for an eligible couple are followed for the net income calculation, even if the spouse is not receiving or applying for SSI or Medicaid benefits;
   b. For a couple living with a child defined in A.A.C. R9-22-1507(A)(2), a child allocation using the methodology described in 20 CFR 416.1163(b)(1) and (2) is allowed as a deduction from the combined net income of the couple for each child regardless of whether a child is eligible for SSI or Medicaid benefits. Each child's allocation is reduced by that child's income, including public income maintenance payments. 20 CFR 416.1163(b)(1) and (2), May 4, 1989, is incorporated by reference and on file with the Administration and the Secretary of State and contains no future editions or amendments;
   c. For a person who is not living with a spouse but is living with a child defined in A.A.C. R9-22-1507(A)(2), a deduction from the parent's net income using the methodology described in 20 CFR 416.1163(b)(1) and (2) is allowed as an allocation for each child regardless of whether the child is ineligible or eligible. Each child's allocation is reduced by that child's income, including public income maintenance payments. 20 CFR 416.1163(b)(1) and (2), May 4, 1989, are incorporated by reference and on file with the Administration and the Secretary of State and contain no future editions or amendments; and
   d. For a child defined in A.A.C. R9-22-1507(A)(2), income is deemed available from an SSI cash or Medicaid-ineligible parent by allowing an allocation for each SSI cash program or Medicaid-eligible and ineligible child of the parent as a deduction from the parent's income using the methodology described in 20 CFR 416.1165(b). Each child's allocation shall be reduced by that child's income, including public income maintenance payments. 20 CFR 416.1165(b), January 8, 1997, is incorporated by reference and on file with the Administration and the Secretary of State and contains no future editions or amendments.

E. As a condition of eligibility for ALTCS, countable income shall be less than or equal to the following limits:

1. For a person in either the 217 or 236 coverage group specified in R9-28-402(B), 300% of the FBR;
2. For a person or a couple in the SSI-related 210 coverage group specified in R9-28-402(B), 100% of the FBR;
3. For a person who is S.O.B.R.A-related specified in A.A.C. R9-22-1406(I) and R9-22-1406(J) and is:

a. A child born after September 30, 1983, who is at least age 6 but less than age 19; 100% of the FPL, adjusted by household size;
b. A child age 1 through 5, 133% of the FPL, adjusted by household size; or
c. A child less than age 1 or a pregnant woman, 140% of the FPL, adjusted by household size; or

4. For a person whose eligibility is determined under Section 1931 of the Social Security Act under 42 U.S.C. 1396u-1, including a child less than the age of 18 who meets the eligibility criteria for Ribicoff or a caretaker relative of a deprived child, the standards specified in A.A.C. R9-22-1406(H) shall apply. Section 1931 of the Social Security Act under 42 U.S.C. 1396u-1, July 1, 1997, is incorporated by reference and on file with the Administration and the Secretary of State and contains no future editions or amendments.

F. The Director shall determine the amount a person shall pay for the cost of ALTCS services and the post-eligibility treatment of income (share-of-cost) under A.R.S. § 36-2932(L) and 42 CFR 435.725 or 42 CFR 435.726. 42 CFR 435.725, January 19, 1993, and 42 CFR 435.726, July 25, 1994, are incorporated by reference and on file with the Administration and the Secretary of State. These incorporations by reference contain no future editions or amendments. The Director shall consider the following in determining the share-of-cost:

1. Income types excluded by 42 U.S.C. 1382a(b) for determining net income are excluded in determining share-of-cost;
2. SSI benefits paid under 42 U.S.C. 1382(e)(1)(E) and (G) to a person who receives care in a hospital or nursing facility are not included in calculating the share-of-cost;
3. The share-of-cost of a person with a spouse is calculated as follows:
   a. If an institutionalized person has a community spouse defined in 42 U.S.C. 1396r-5(h), share-of-cost is calculated under R9-28-410 and 42 U.S.C. 1396r-5(b) and (d), October 1, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments;
   b. If an institutionalized person has a spouse who does not live at home but is absent due to marital estrangement, or who resides in a medical institution or in an approved setting specified in R9-28-504, only the institutionalized person's income is used for the share-of-cost. The spousal deduction described in subsection (F)(5)(b) is not allowed; and
   c. For all other persons, the share-of-cost is calculated by dividing the combined income of the spouses in half;
4. Income assigned to a trust is considered in accordance with federal and state law.
5. The following expenses are deducted from the share-of-cost of an eligible person to calculate their share-of-cost:
   a. A personal-needs allowance equal to 15% of the FBR for a person residing in a medical institution for a full calendar month. A personal-needs allowance equal to 300% of the FBR for a person who receives or intends to receive HCBS or who resides in a medical institution for less than the full calendar month;
   b. A spousal allowance, equal to the FBR minus the income of the spouse, if a spouse but no children remain at home;
   c. A family allowance equal to the standard for the 1931 coverage group specified inA.A.C. R9-22-1406(B) for the number of family members minus the income of the family members if a spouse and children remain at home;
   d. Expenses for the medical and remedial care services listed in subsection (F)(6) if these expenses have not been paid or are not subject to payment by a 3rd party, but the person still has the obligation to pay the expense, and 1 of the following conditions is met:
      i. The expense represents a current payment (that is, a payment made and reported to the Administration during the application period or a payment reported to the Administration no later than the end of the month following the month in which the payment occurred) and the expense has not previously been allowed a share-of-cost deduction; or
      ii. The expense represents the unpaid balance of an allowed, noncovered medical or remedial expense, and the expense has not been previously deducted from the share-of-cost;
   e. An amount determined by the Director for the maintenance of a single person's home for not longer than 6 months if a physician certifies that the person is likely to return home within that period; or
   f. An amount for Medicare and other health insurance premiums, deductibles, or coinsurance not subject to 3rd-party reimbursement; and
6. In the post-eligibility calculation of income, the Administration recognizes the following medical and remedial care services are not covered under the Title XIX State Plan, nor covered by a program contractor to a person determined to need institutional services under this Article when the medical or remedial care services are medically necessary for a person:
   a. Nonemergency dental services for a person who is age 21 or older;
   b. Hearing aids and hearing aid batteries for a person who is age 21 or older;
   c. Nonemergency eye care and prescriptive lenses for a person who is age 21 or older;
   d. Chiropractic services, including treatment for subluxation of the spine, demonstrated by x-ray;
   e. Orthognathic surgery for a person 21 years of age or older; and
   f. On a case-by-case basis, other noncovered medically necessary services that a person petitions the Administration for and the Director approves.

G. A person shall provide information and verification of income under A.R.S. § 36-2934(G) and 20 CFR 416.203, November 26, 1985, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation contains no future editions or amendments.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-409. Transfer of Assets

A. The provisions in this Section apply to an institutionalized person who has, or whose spouse has, transferred assets and received less than the fair market value (uncompensated value) specified in A.R.S. § 36-2934(B) and 42 U.S.C. 1396p(c)(1)(A), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. A person shall report transfer of assets. The Administration shall evaluate all transfers occurring during or after the look-back period under 42 U.S.C. 1396p(c)(1)(B), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments. The person shall provide verification of any transfer.

C. Certain transfers are permitted under 42 U.S.C. 1396p(c)(2), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

D. If the Administration determines a disqualification period applies due to a transfer, and the person is otherwise eligible, the person may remain eligible for ALTCS acute care services but shall be disqualified for receiving ALTCS coverage under 42 U.S.C. 1396p(c)(1)(C), August 10, 1993, which is incorporated by reference and on file with the Administration and the Secretary of State. This incorporation contains no future editions or amendments.

E. The period of disqualification for transfers shall be computed by dividing the cumulative uncompensated value of the transferred assets by the average cost for a private pay patient for nursing care services at the time of application.

1. For single or multiple transfers occurring in the same calendar month, the sum of all uncompensated value shall be divided by the monthly private pay rate. Disregarding fractions, the result of this calculation equals the number of months of ineligibility.
2. For multiple transfers occurring in different calendar months, the total uncompensated value for each transfer of assets shall be determined under subsection (E)(1) but, if the periods of ineligibility overlap, the period of ineligibility shall run consecutively. Fractions are disregarded at the end of the entire period.
3. For multiple transfers occurring in different months, the total uncompensated value for each transfer shall be determined under subsection (E)(1), but if the periods of ineligibility do not overlap, each period of ineligibility shall be treated under subsection (E)(1).

F. Transfers of assets for less than fair market value are presumed to have been made to establish eligibility for ALTCS services.

G. Rebuttal of disqualification.

1. A person found ineligible for ALTCS services by reason of a transfer of assets for uncompensated value shall have the right to rebut the disqualification under 42 U.S.C. 1936p(c)(2)(C), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
2. The person shall have the burden of rebutting the presumption.
3. If a person rebuts a transfer on the basis of debt repayment, the Administration shall determine the validity of the debt under A.R.S. § 44-101.

H. Undue hardship. A period of disqualification for ALTCS services due to a transfer may be waived by the Director if the person is otherwise eligible and a substantial showing is made by clear and convincing evidence that:

1. The person is unable to obtain necessary medical care without ALTCS eligibility, and
2. Is in imminent danger of death.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-410. Community Spouse

A. The methodology in this Section applies to an institutionalized person who is legally married and has a spouse who resides in the community.

B. If the institutionalized person's most current period of continuous institutionalization began on or after September 30, 1989, the Administration shall use the methodology for the treatment of resources under 42 U.S.C. 1396r-5(c), September 30, 1989, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

1. The following resource criteria shall be used in addition to the criteria specified in R9-28-407:
   a. Resources owned by a couple at the beginning of the 1st continuous period of institutionalization from and after September 30, 1989, shall be computed from the 1st day of institutionalization. The total value of resources owned by the institutionalized spouse and the community spouse, and a spousal share equal to 1/2 of the total value, are computed under 42 U.S.C. 1396r-5(c)(1), September 30, 1989, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation contains no future editions or amendments.
   b. The Community Spouse Resource Reduction (CSRD) is calculated under 42 U.S.C. 1396r-5(f)(2), September 30, 1989, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
   c. The CSRD is subtracted from the total resources of the couple to determine the amount of the couple's resources considered available to the institutionalized spouse at the time of application under 42 U.S.C. 1396r-5(c)(2), September 30, 1989, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
      i. Resources in excess of the CSRD must be equal to or less than the standard for a person specified in R9-28-407.
      ii. The CSRD is allowed as a deduction for 12 consecutive months beginning with the 1st month in which the institutionalized spouse is eligible for ALTCS benefits. Beginning with the 13th month, the separate property of the institutionalized spouse must be within the resource standard for a person specified in R9-28-407.
      iii. If a person, previously eligible for ALTCS using the community spouse policy, reapplies for ALTCS after a break in institutionalization of more than 30 days, the CSRD will be allowed as a deduction from resources for another 12-month period.
2. Resources are excluded as specified in R9-28-407, except that 1 vehicle is totally excluded regardless of its value, and any additional vehicles are included using equity value.
3. The Director may grant eligibility if the Administration determines a denial of eligibility would create an undue hardship.

C. The community spouse policy applies to the income eligibility and post-eligibility treatment of income beginning September

30, 1989, regardless of when the 1st period of institutionalization began.

1. Income payments are attributed to the institutionalized spouse and the community spouse under 42 U.S.C. 1396r-5(b)(2), October 1, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
2. Income is excluded specified in R9-28-408.
3. The institutionalized spouse's income eligibility is determined under community property rules in which the income of the spouse is combined and divided by 2. Income eligibility shall be based on the income received in the person's name if the person is not eligible using community property rules.
4. The items described in 42 U.S.C. 1396r-5(d)(1) and (2) are allowed as deductions from the institutionalized spouse's income in determining share-of-cost and 42 U.S.C. 1396r-5(d)(1) and (2), September 30, 1989, are incorporated by reference and on file with the Administration and the Secretary of State and contain no future editions or amendments:
   a. A personal-needs allowance specified in R9-28-408(f)(5)(a);
   b. A community spouse monthly income allowance, but only to the extent that the institutionalized spouse's income is made available to or for the benefit of the community spouse;
   c. A family allowance for each family member equal to 1/3 of the amount remaining after deducting the countable income of the family member from a minimum monthly-needs allowance;
   d. An amount for medical or remedial services specified in R9-28-408; and.
   e. An amount for Medicare and other health insurance premiums, deductibles, or coinsurance not subject to 3rd-party reimbursement.

D. Transfers.

1. The institutionalized spouse may transfer to any of the following an amount of resources equal to the CSRD without affecting eligibility under 42 U.S.C. 1396r-5(f), September 30, 1989, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments. The institutionalized spouse may transfer resources to:
   a. The community spouse; or
   b. Someone other than the community spouse if the resources are for the sole benefit of the community spouse.
2. The institutionalized spouse is allowed a period of 12 consecutive months, beginning with the 1st month of eligibility, to transfer resources in excess of the resource standard in R9-28-407(E)(2) to the persons listed in subsection (D)(1).
3. All other transfers by the institutionalized person or transfers by the community spouse are treated under the provisions in R9-28-409.

E. Specific hearing rights apply to a person whose eligibility is determined under this Section.

1. The institutionalized spouse or the community spouse is entitled to a fair hearing if dissatisfied with the determination of any of the following:
   a. The community spouse monthly income allowance;
   b. The amount of monthly income allocated to the community spouse;
   c. The computation of the spousal share of resources;
   d. The attribution of resources; or
   e. The CSRD.
2. The hearing officer may increase the amount of the MMMNA if either spouse establishes that the community spouse needs income above the established MMMNA due to exceptional circumstances.
3. The hearing officer may increase the amount of the CSRD to allow the community spouse to retain enough resources to generate income to meet the MMMNA. The community spouse may be allowed to retain an amount of resources necessary to purchase a single premium life annuity that would furnish monthly income sufficient to bring the community spouse's total monthly income up to the MMMNA.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-411. Changes, Redeterminations, and Notices

A. Reporting and verifying changes**.**

1. A person shall report to the ALTCS eligibility office the following changes for a person, a person's spouse, or a person's dependent children under 42 CFR 435.916:
   a. A change of address;
   b. An admission to or discharge from a medical facility, public institution, or private institution;
   c. A change in the household's composition;
   d. A change in income;
   e. A change in resources;
   f. A determination of eligibility for other benefits;
   g. A death;
   h. A change in marital status;
   i. An improvement in the person's medical condition;
   j. A change in school attendance;
   k. A change in Arizona state residency;
   l. A change in citizenship or alien status;
   m. Receipt of an SSN under R9-28-405;
   n. A transfer of assets under R9-28-409;
   o. A change in trust income and disbursements in accordance with state and federal law;
   p. A change in 1st- or 3rd-party liability that may be responsible for payment of all or a portion of the person's medical costs;
   q. A change in 1st-party medical insurance premiums;
   r. A change in the household expenses used to calculate the community spouse monthly income allowance described in R9-28-410;
   s. A change in the amount of the community spouse monthly income allowance that is provided to the community spouse by the institutionalized spouse under R9-28-410; and
   t. Any other change that may affect the person's eligibility or share-of-cost.
2. A change shall be reported either orally or in writing and shall include:
   a. The name of the affected person;
   b. The change;
   c. The date the change happened;
   d. The name of the person reporting the change; and
   e. The person's Social Security or case number, if known, under A.R.S. § 36-2934.
3. A person shall provide verification of changes upon request, under A.R.S. § 36-2934, if needed to redetermine eligibility or to re-calculate post-eligibility computation of income.

4. A person shall report anticipated changes in advance, as soon as the future event becomes known.
5. A person shall report other changes events within 10 days of the date the change occurred.

B. Processing of changes and redeterminations. A person's eligibility shall be redetermined at least 1 time every 12 months and when changes occur, under 42 CFR 435.916. A person's share-of-cost, specified in R9-28-408, shall be redetermined whenever a change occurs that may affect the post-eligibility computation of income.

C. Actions that may result from a redetermination or change. Processing a redetermination or change shall result in 1 of the following findings:
1. No change in eligibility or the post-eligibility computation of income;
2. Discontinuance of eligibility if a condition of eligibility is no longer met;
3. Suspension of eligibility if a condition of eligibility is temporarily not met;
4. A change in the post-eligibility computation of income and the person's share-of-cost; or
5. A change in service from ALTCS to ALTCS acute care services, or from ALTCS acute care services to ALTCS, caused by changes in a person's living arrangement, specified in R9-28-406, or a transfer of assets specified in R9-28-409.

D. Notices.
1. Contents of notice. The Administration shall issue a notice when an action is taken regarding a person's eligibility or computation of share-of-cost. The notice shall contain the following information:
   a. A statement of the action being taken;
   b. The effective date of the action;
   c. The specific reason for the intended action;
   d. The actual figures used in the eligibility determination and specify the amount by which the person exceeds income standards if eligibility is being discontinued because either a person's resources exceed the resource limit specified in R9-28-407(E), or a person's income exceeds the income limit specified in R9-28-408(E);
   e. The specific law or regulation that supports the action, or a change in federal or state law that requires an action;
   f. An explanation of a person's right to request an evidentiary hearing; and
   g. An explanation of the date by which a request for hearing must be received so that eligibility or the current share-of-cost may be continued.
2. Advance notice of changes in eligibility or share-of-cost. "Advance notice" means a notice that is issued to a person at least 10 days before the effective date of change, under 42 CFR 435.919. Except as specified in subsection (D)(3), advance notice shall be issued whenever the following adverse action is taken:
   a. To discontinue or suspend eligibility if an eligible person no longer meets a condition of eligibility, either ongoing or temporarily;
   b. To affect post-eligibility computation of income and increase a person's share-of-cost; or
   c. To reduce benefits from ALTCS to ALTCS acute care services due to a change from a long-term care living arrangement to an acute care living arrangement, specified in R9-28-406(B), or due to a transfer with uncompensated value, specified in R9-28-409.
3. Under 42 CFR 431.213, notice shall be issued to a person to discontinue eligibility or to increase the share-of-cost, no later than the effective date of action if:
   a. A person provides a clear, written statement, signed by the person, that a person no longer desires services;
   b. A person provides information that requires termination of eligibility or an increase in the share-of-cost and the person signs a clear written statement waiving advance notice;
   c. A person cannot be located and mail sent to that person has been returned as undeliverable;
   d. A person has been admitted to a public institution where the person is ineligible for ALTCS under R9-28-406; or
   e. A person has been approved for Medicaid in another state;
   f. The Administration has information that confirms the death of the person;
   g. The person's primary care provider has prescribed a change in the level of medical care; or
   h. The notice involves an adverse determination regarding the PAS, specified in A.R.S. § 36-2536.

E. Transitional. HCBS services may be provided to a person who is no longer at risk of institutionalization but who continues to require significant long-term care services under A.R.S. § 36-2936(D).

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-412. Enrollment with an ALTCS Program Contractor

A. Enrollment with appropriate ALTCS program contractor. As soon as a decision is reached that a person is eligible for ALTCS benefits, a person shall be enrolled under A.R.S. § 36-2933 with either:
1. The DES Division of Developmental Disabilities if a person is developmentally disabled;
2. An ALTCS tribal contractor if the person is a Native American living on the reservation of a tribe participating as an ALTCS tribal contractor;
3. An ALTCS program contractor; or
4. ALTCS fee-for-service if there is no ALTCS tribal or program contractor and the person is not developmentally disabled.

B. Effective date of ALTCS enrollment for a person not enrolled with an acute care health plan.
1. With the exception of prior quarter eligibility under R9-28-401(G), a person shall be enrolled with the appropriate program contractor, as determined by subsection (A), retroactive to the 1st day of the month in which the person became eligible for the ALTCS program.
2. Prior quarter eligibility benefits, specified in R9-28-401(G), are covered by the Administration on a fee-for-service basis.

C. Effective date of ALTCS enrollment for a person enrolled with an acute care health plan. If a person is eligible for AHCCCS acute care program and is approved for ALTCS coverage, disenrollment with a contractor who provides services specified in. R9-22-101 and enrollment with the ALTCS tribal or program contractor is effective on the date that the ALTCS approval is posted on the AHCCCS Prepaid Medical Management Information System (PMMIS). The contractor in which the person is enrolled is responsible for AHCCCS covered services until that date.

D. Notification to the ALTCS tribal or program contractor. A contractor shall be notified whenever a person is enrolled or disenrolled with that contractor. Notification shall include the person's name, identification number, and the effective date of enrollment or disenrollment.

E. Responsibilities of ALTCS tribal or program contractors.
1. The ALTCS program contractor is responsible for all AHCCCS covered services provided to an enrolled person until the person is disenrolled.
2. An eligible and enrolled person shall be assigned a case manager by the ALTCS program contractor.
3. The ALTCS tribal contractor is responsible for the coordination of services specified in the tribe's intergovernmental agreement (IGA) with the Administration.
4. The ALTCS tribal or program contractor shall notify the Administration if an ALTCS eligible person has any change that may affect eligibility including:
   a. Residential address;
   b. County of residence;
   c. Facility; or
   d. Death.

F. Disenrollment.
1. An eligible person who dies shall be disenrolled from the ALTCS tribal or program contractor effective the day after the date of death.
2. An eligible person who loses ALTCS eligibility for any other reason shall be disenrolled following the receipt of appropriate notification under R9-28-411.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

ARTICLE 5. PROGRAM CONTRACTOR AND PROVIDER STANDARDS

R9-28-501. General Provisions

A. An eligible person or member may receive the covered services specified in Article 2 of this Chapter. A program contractor shall provide and coordinate services for a member enrolled with the program contractor. The Administration shall provide and coordinate ALTCS-covered services to an eligible person or member in counties where there is no program contractor. The Department of Economic Security, in its role as a program contractor, shall provide and coordinate services to an eligible person or member with developmental disabilities, as defined in A.R.S. § 36-551.

B. To participate in the ALTCS program, through a program contractor or directly through the Administration, a provider of ALTCS-covered services shall be registered with the Administration.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4).

R9-28-502. Long-term Care Provider Requirements

A. A provider shall obtain any necessary authorization from the program contractor or the Administration for services provided to an ALTCS-eligible person or member.

B. A provider shall maintain and make available to a program contractor and to the Administration, financial, and medical records for not less than 5 years from the date of final payment, or for records relating to costs and expenses to which the Administration has taken exception, 5 years after the date of final disposition or resolution of the exception. The records shall meet the uniform accounting standards as specified by the Administration, and accepted practices for maintenance of medical records, including detailed specification of all patient services delivered, the rationale for delivery, and the service date.

C. A provider shall not submit a claim, demand, or otherwise collect payment from an eligible person or member for ALTCS-covered services paid to the provider by the Administration or program contractor. A provider shall not bill or attempt to collect payment, directly or through a collection agency, from a person claiming to be ALTCS eligible without first receiving verification from the Administration that the person was ineligible for ALTCS on the date of service, or that services provided were not ALTCS-covered services.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsection (E) effective June 6, 1989 (Supp. 89-2). Amended effective December 8, 1997 (Supp. 97-4).

R9-28-503. Licensure and Certification for Long-term Care Institutional Facilities

A. Nursing facilities that provide services to an eligible person or member shall be Medicare and Medicaid certified and meet the requirements in 42 CFR 442, September 28, 1995, and 42 CFR 483, September 29, 1995, incorporated by reference and on file with the Administration and the Office of the Secretary of State, and meet the Arizona Department of Health Services' rules for licensure. This incorporation by reference contains no future editions or amendments.

B. An ICF-MR shall be Medicaid certified and meet the requirements in A.R.S. § 36-2939(B)(1) and 42 CFR 442, Subpart C, November 20, 1992, and 42 CFR 483, September 29, 1995, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

C. All nursing facilities and ICF-MRs that provide services to an eligible person or member shall be registered as providers with the Administration. To be registered, a provider shall meet the licensure and certification requirements of subsections (A) or (B) and have a current provider agreement with a program contractor.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective November 5, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4).

R9-28-504. Standards of Participation, Licensure, and Certification for HCBS Providers

A. All noninstitutional long-term care providers shall be registered with the Administration and meet the requirements of the Arizona Department of Health Services' rules for licensure, if applicable.

B. Additional qualifications:
1. A community residential setting and a group home for an individual with developmental disabilities shall be licensed by the appropriate regulatory agency of the state according to 6 A.A.C. 6;
2. An adult foster care home shall be certified or licensed according to 9 A.A.C. 10;
3. A home health service agency shall be Medicare-certified and licensed according to 9 A.A.C. 10;
4. An individual providing a homemaker service shall meet the requirements specified in contract;

5. An individual providing a personal care service shall meet the requirements specified in contract;
6. An adult day health provider shall be licensed according to 9 A.A.C. 10;
7. A therapy provider shall meet the following requirements:
   a. A physical therapy provider shall meet the requirements in 4 A.A.C. 24;
   b. A speech therapy provider shall be certified by the American Speech, Language, and Hearing Association;
   c. An occupational therapy provider shall meet the requirements in 4 A.A.C. 43; and
   d. A respiratory therapy provider shall meet the requirements in 4 A.A.C. 45;
8. A respite provider shall meet the requirements specified in contract;
9. A hospice provider shall be Medicare-certified and licensed according to 9 A.A.C. 10;
10. A provider of home delivered meal service shall comply with hygiene requirements in 9 A.A.C. 8;
11. A provider of non-emergency transportation shall be licensed by the Arizona Department of Transportation, Motor Vehicle Division;
12. A provider of emergency transportation shall meet the licensure requirements in 9 A.A.C. 13;
13. A day care provider for the developmentally disabled shall meet the licensure requirements in 6 A.A.C. 6;
14. A habilitation provider shall meet the requirements in A.A.C. R6-6-1523 or the therapy requirements in this Section;
15. Another service provider approved by the director shall meet the requirements specified in a program contractor's contract with the Administration;
16. A behavioral health provider shall have all applicable state licenses or certifications, and meet the service specifications in A.A.C. R9-22-1205;
17. An assisted living home or a residential unit as defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1).

R9-28-505. Standards, Licensure and Certification for Providers of Hospital and Medical Services

A. A provider of hospital and medical care services shall be registered with the Administration.

B. With the exception of an Indian Health Service (IHS) hospital and a Veterans Administration hospital, which must be Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited, a provider of hospital services shall be licensed by the Arizona Department of Health Services, be JCAHO accredited, and meet the requirements in 42 CFR 482, September 9, 1996, and 42 CFR 456(C), September 29, 1978, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation contains no future editions or amendments.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4).

R9-28-506. Reserved

R9-28-507. Program Contractor General Requirements

A. ALTCS program contractors shall ensure that providers of service meet the requirements of this Article.

B. Each ALTCS program contractor shall maintain member service records. These shall include, at a minimum, a case management plan, medical records, encounter data, grievances, complaints, and service information for each ALTCS member. A program contractor shall ensure that all member service records are retained for 5 years from the date of final payment or, for records relating to costs and expenses to which the Administration has taken exception, 5 years after the date of final disposition or resolution of the exception. A program contractor shall provide ALTCS member service records or copies of member service records to the Administration upon request.

C. An ALTCS program contractor shall produce and distribute information materials to each enrolled ALTCS member or designated representative within 10 days after receipt of notification of enrollment from the Administration. The information, which shall be approved by the Administration before distribution, shall include:
1. A description of all available services;
2. An explanation of service limitations and exclusions;
3. An explanation of the procedure for obtaining services, including a notice stating that the program contractor is liable only for those services authorized by an ALTCS member's case manager;
4. An explanation of the procedure for obtaining emergency services; and
5. An explanation of the procedure for filing a grievance and appeal.

D. An ALTCS program contractor shall submit encounter reports on services rendered to each member within 120 days after the month of service, except for services with Medicare coverage, which shall be submitted within 180 days after the month of service.

E. An ALTCS program contractor or subcontractor shall collect the member's share of cost and report the amount collected as specified in their contract to the program contractor or Administration, if necessary.

F. An ALTCS program contractor shall monitor a trust fund account for an institutionalized ALTCS member to verify that expenditures from the member's trust fund account are in compliance with federal regulations.

G. A program contractor shall ensure that an institutionalized ALTCS member who is transferred to an acute facility for services is, whenever possible, returned to the original institution upon completion of acute care.

H. A program contractor shall ensure that an institutionalized ALTCS member who is granted therapeutic leave is returned to the same bed in the original institution upon completion of the therapeutic leave.

I. Program contractors shall ensure that services are provided according to A.A.C. R9-22-705.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3).

R9-28-508. Program Contractor Standards - Submittal of Comprehensive Plan for Delivery of Services

A program contractor shall annually submit a comprehensive plan for delivery of services under the ALTCS program as specified in the RFP during bid years or the RFP amendment during renewal years. The program contractor shall ensure that the comprehensive service delivery plan describes the methods and procedures to be used by the program contractor in complying with the standards defined in this Article, and in providing services to an eligible person or member.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Amended effective December 8, 1997 (Supp. 97-4).

R9-28-509. Reserved

R9-28-510. Case Management

A. Each eligible person and member shall be assigned a case manager to:
1. Identify,
2. Plan,
3. Coordinate,
4. Monitor, and
5. Reassess the need for and provision of long-term care services.

B. The case manager shall:
1. Ensure that appropriate ALTCS placement and services are provided for an eligible person or member within 30 days of notification of enrollment;
2. Complete a case management plan when an eligible person or member is enrolled in ALTCS. The case manager shall re-evaluate and revise the plan when the eligible person or member:
   a. Transfers to another facility,
   b. Transfers to a hospital,
   c. Has a change in the in-home service package, or
   d. Has a change in the level of care.
3. Specify the services to be received by an eligible person or member, including the:
   a. Duration,
   b. Scope of services,
   c. Units of service,
   d. Frequency of service delivery,
   e. Provider of services, and
   f. Effective time period.
4. Authorize services for an eligible person or member who continues to be financially and medically eligible for services;
5. Coordinate with a primary care provider in determining the necessary services for an eligible person or member, including hospital and medical services;
6. Ensure that an eligible person or member participates in the preparation of the eligible person's or member's case management plan;
7. Assist an eligible person or member to maintain or progress toward the highest level of functioning;
8. Monitor receipt of services by an eligible person or member;
9. Initiate a transfer to AHCCCS or other programs, where appropriate, when ALTCS HCBS services are no longer necessary;
10. Submit written justification to the case manager's supervisor to include HCBS in the case management plan, if the services exceed 80% of the institutional cost;
11. Ensure that records are transferred when an eligible person or member is transferred from a facility or provider to a new facility or provider;
12. Perform additional monitoring of an eligible person or member with rehabilitation potential, whose condition is fragile or unstable, whose case management plan is marginally cost effective, or whose use of medical and hospital services is unusual;
13. Revise a case management plan for an eligible person or member according to the terms of the contract; and
14. Arrange behavioral health services if necessary and, if the case manager does not meet the definition of a behavioral health professional according to A.A.C. R9-22-1201, have initial and quarterly consultation and collaboration with a behavioral health professional to review the treatment plan.

C. A program contractor shall submit the initial case management plan and all revisions to the Administration within 14 days of initially preparing or revising the plan.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that the amendment was not reviewed by the Governor's Regulatory Review Council; the agency did not submit a notice of proposed rulemaking for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rulemaking; and the Attorney General has not certified the rule. This Section was subsequently amended through the regular rulemaking process.

R9-28-511. Quality Management/Utilization Management (QM/UM) Requirements

A program contractor shall:
1. Comply with all requirements specified in A.A.C. R9-22-522; and
2. Submit a quarterly utilization control report within time lines specified in contract and specified in 42 CFR 456 Subparts C, D, and F, December 1, 1986, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 1, 1993 (Supp. 93-1). Amended effective November 5, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1).

R9-28-512. Financial Statements, Periodic Reports and Information

The Administration and its contractors shall meet the requirements specified in A.A.C. R9-22-520.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4).

R9-28-513. Program Compliance Audits
The Administration and its contractors shall meet the requirements specified in A.A.C. R9-22-521 for an ALTCS eligible person or member.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4).

R9-28-514. Release of Safeguarded Information by the Administration and Contractors
The Administration, program contractors, providers, and noncontracting providers shall meet the requirements specified in A.A.C. R9-22-512 for an ALTCS applicant, eligible person, or member.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4).

R9-28-515. Discrimination prohibition and equal opportunity
The program contractor and provider shall comply with discrimination prohibitions and equal opportunity requirements as set forth in A.A.C. R9-22-513 and R9-22-514.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3).

ARTICLE 6. PROGRAM CONTRACTS AND PROCUREMENT PROCESS

R9-28-601. General
A. The Administration shall establish contracts to provide services under ALTCS with qualified program contractors in conformance with the requirements in this Article.
B. Contracts and subcontracts entered into as specified in this Article are public records on file with the Administration.
C. Except as otherwise provided by law, this Article applies to the expenditure of all public monies, including federal assistance monies, by the Administration for ALTCS services.
D. The Director may conduct an investigation of a person who has ownership or management interests in an offeror or an affiliated organization of the offeror. The Administration shall have in effect conflict of interest safeguards with respect to an officer and an employee of the state with responsibilities relating to contracts and the contract procurement process specified in 42 U.S.C. 1396u-2, as of August 5, 1997, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
E. All information contained in a proposal is confidential so as to avoid disclosure of contents to competing offerors during the process of discussions. The Administration shall open proposals for public inspection after contract award, unless upon an offeror's written request for nondisclosure, the Director makes a determination that disclosure is not in the best interest of the state.
F. Failure of an offeror to supply information required by the RFP is a basis for rejecting the offeror's proposal.
G. Disclosure by an offeror of the terms of its proposal to another offeror or to any other individual before contract award is prohibited and may be grounds for rejecting the disclosing offeror's proposal.
H. The Administration shall retain all contract records for 5 years and dispose of these as specified in A.R.S. § 41-2550.
I. A contractor shall not knowingly have a director, an officer, a partner, or a person with ownership of more than 5% of a contractor's equity who has been debarred or suspended by any federal agency as specified in 42 U.S.C. 1396u-2, as of August 5, 1997, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
J. The Administration shall certify a contractor as a risk-bearing entity as specified in A.R.S. § 36-2932, as specified in RFP and contract, and as specified in 42 U.S.C. 1396b(m), as of August 5, 1997, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1).

R9-28-602. Contracts
Each contract between the Administration and a program contractor shall be in writing and contain at least the information listed:
1. The method and amount of compensation or other consideration to be received by the program contractor;
2. The name and address of the program contractor;
3. The population to be covered by the contract;
4. The amount, duration, and scope of services to be provided or for which compensation will be paid;
5. The term of the contract, including the beginning and ending dates, as well as methods of extension, renegotiation, and termination;
6. A provision that the Director or the Secretary of the U.S. Department of Health and Human Services may evaluate, through inspection or other means, the quality, appropriateness, or timeliness of services performed under the contract;
7. A description of the member services, medical and cost recordkeeping systems, and a provision that the Director or the Secretary of the U.S. Department of Health and Human Services may audit and inspect any of the program contractor's records that pertain to services performed and determinations of amounts payable under the contract. These records shall be maintained by the program contractor for 5 years from the date of final payment or, for records relating to costs and expenses to which the Administration has taken exception, 5 years after the date of final disposition or resolution of the exception;
8. A provision that the program contractor maintain all forms, records, and statistical information required by the Director for purposes of audit and program management. These materials, including files, correspondence, and related information pertaining to services rendered or claims for payments, are subject to inspection and copying by the Administration and the U.S. Department of Health and Human Services during normal business hours at the place of business of the individual or organization maintaining the materials;
9. A provision that the program contractor safeguard confidential information as required by 42 CFR 431, Subpart F;
10. The functions that may not be subcontracted;
11. A provision that the program contractor arrange for the collection from all probable sources of 1st- and 3rd-party liability except for uninsured and underinsured

motorist insurance, 1st- and 3rd-party liability insurance, and tort-feasors;

12. A provision that the program contractor not bill or attempt to collect from a member for any covered service except as may be authorized by statute or this Chapter;
13. A provision that the contract not be assigned or transferred without the prior written approval of the Director;
14. The procedures for enrollment or re-enrollment of the members;
15. The procedures and criteria for terminating the contract;
16. A provision that any cost-sharing requirements imposed for services furnished to members are in accordance with 42 CFR 447.50 through 447.58 as of December 19, 1990, which are incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments;
17. A provision that specifies the actuarial basis for computation of capitation fees, if applicable;
18. A provision for terminating enrollment;
19. A provision for choosing a health professional;
20. A provision that the program contractor provide for an internal grievance procedure that:
    a. Is approved in writing by the Administration;
    b. Provides for prompt resolution; and
    c. Ensures the participation of individuals with authority to require corrective action.
21. A provision that the program contractor maintain a comprehensive internal quality management system consistent with ALTCS rules;
22. A provision that the program contractor submit marketing plans, procedures, and materials to the Administration for approval before implementation;
23. A statement that all representations made by the program contractor or its authorized representative are truthful and complete to the best of its knowledge;
24. A provision that the program contractor is responsible for all tax obligations, Workers' Compensation Insurance, and all other applicable insurance coverage, for itself and its employees, and that the Administration has no responsibility or liability for any of the taxes or insurance coverageof the program contractor or its subcontractors;
25. A provision that the program contractor agrees to comply with all applicable federal and state statutes and rules;
26. A provision that the program contractor report each member's case management plan and any changes in a manner prescribed by the Director;
27. A provision that members needing therapeutic leave or bed-hold days be returned to the same facility;
28. A provision that the program contractor submit all RFPs for services to the Administration for review and written approval before issuance;
29. A provision that the program contractor submit an annual plan in response to the annual contract renewal amendment as defined in A.R.S. § 36-2940 to the Administration;
30. An agreement to hold harmless and indemnify the state, the Director, the Administration, and members against claims, liabilities, judgments, costs, and expenses with respect to 1st and 3rd parties, which may accrue against the state, the Director, the Administration, or members, through the negligence, omission, or intentional conduct of the program contractor;
31. A provision that the program contractor establish and implement a plan for preventing fraud or abuse by members, providers, and noncontracting providers;
32. A provision that the program contractor comply with all 1st- and 3rd-party liability and coordination of benefits requirements established by state and federal rules;
33. A provision that the program contractor comply with financial and performance audit standards that satisfy R9-28-512 and R9-28-513;
34. A provision that the program contractor comply with inspection of care reviews;
35. A provision that the program contractor may forfeit payments if the program contractor fails to comply with the provisions of its contract or this Chapter;
36. A provision that the program contractor establish and submit to the Administration for approval a utilization control system plan that satisfies A.R.S. § 36-2947 and 9 A.A.C. 28, Article 5;
37. A provision that the program contractor develop and submit to the Administration for approval a plan for its case management system that satisfies R9-28-510;
38. A provision that the program contractor notify the Administration if a member is no longer eligible due to death or a move out of the state;
39. A provision that the program contractor comply with the uniform accounting system established by the Administration;
40. A provision that the program contractor may forfeit funds to the Administration to recompense it for federal sanctions or penalties placed on the Administration for errors made by the program contractor;
41. A provision that the program contractor suspend or reduce services upon notification by the Administration under A.R.S. § 36-2958;
42. A provision that the program contractor provide encounter reporting in the form and format prescribed by the Administration; and
43. A provision that if, at any time, federal monies are denied, not received, or become unavailable for any reason, the operation of ALTCS is suspended.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective August 11, 1997 (Supp. 97-3).

R9-28-603. Subcontracts

A. Approval. When a program contractor enters into any subcontract or amends any subcontract to provide covered services to ALTCS members, the subcontracts shall be subject to review and prior written approval by the Director. A subcontract does not alter the legal responsibility of a program contractor to the Administration to ensure that all activities under the contract are carried out.

B. Subcontracts. Each subcontract shall be in writing and include the requirements listed below:

1. A provision that the subcontract be governed by, and construed in accordance with all laws, rules, and contractual obligations of the program contractor;
2. A provision to notify the Administration in the event the agreement with the program contractor is amended or terminated;
3. A provision that assignment or delegation of the subcontract is void unless prior written approval is obtained from the Administration;

4. A provision to hold harmless the state, the Director, the Administration, and members in the event the program contractor cannot or will not pay for covered services performed by the provider;
5. A provision that the subcontract and subcontract amendments are subject to review and approval by the Administration as required in this Chapter and that a subcontract or subcontract amendment may be terminated, rescinded, or canceled by the Administration for a violation of this Chapter;
6. A provision to hold harmless and indemnify the state, the Director, the Administration, and members against claims, liabilities, judgments, costs, and expenses with respect to 1st- and 3rd-parties, which may accrue against the state, the Director, the Administration, or members through the negligence, omission, or intentional conduct of the provider;
7. The requirements contained in R9-28-602(A)(1) through (7), (9), (10), (14), (15), (17), and (23) through (25) with the term "provider" substituted wherever the term "program contractor" is used; and
8. A provision that members are not held liable for payment to providers in the event of the program contractor's bankruptcy, in compliance with 42 CFR 434, Subpart C, June 27, 1995, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3).

R9-28-604. Request for Proposals (RFP); Contract Award

A. The Director may cancel or reject any or all requests for proposals in whole or in part if it is deemed by the Director to be in the best interests of the state. The reason for cancellation or rejection shall be made part of the contract file.

B. RFP content. The Administration shall include the following items in a RFP:
1. The instructions and information to offerors concerning the proposal submission requirements, including:
   a. The time and date set for the proposal submission deadline,
   b. The address of the office at which proposals are to be received, and
   c. The period during which the proposal shall remain open and any other special information;
2. The service description, covered populations, geographic coverage, specifications, and a delivery or performance schedule;
3. The contract terms and conditions, including bonding or other security requirements, if applicable;
4. A provision for a 2nd-round competitive procedure to request voluntary price reductions of bids from only those offerors that have been tentatively selected for award, if applicable;
5. The factors to be used in the evaluation of proposals;
6. The location of and method for obtaining documents that are incorporated by reference;
7. A provision that the offeror acknowledge receipt of all RFP amendments issued by the Administration;
8. The type of services required and a description of the work involved;
9. The type of contract to be used and a copy of a proposed contract form or provisions;
10. The estimated length of time during which service will be required;
11. The minimum information that the proposal contain; and
12. A provision that the offeror certify that submission of the proposal does not involve collusion or other anti-competitive practice.

C. Evaluation of proposals.
1. As provided in the RFP the Administration may conduct discussions with responsible offerors that submit proposals determined to be reasonably susceptible to being selected for award. The Administration shall accord offerors fair treatment with respect to any opportunity for discussion and revision of proposals, and may permit revisions after submission and before award for the purpose of obtaining best and final offers. In conducting discussions, the Administration shall not disclose any information derived from proposals submitted by competing offerors.
2. As part of its discussions, the Administration may conduct a 2nd-round competitive procedure to request voluntary price reductions from offerors that have been tentatively selected for award, before the final award or rejection of proposals.
3. If discussions are conducted under subsection (C)(1), the Administration may issue a written request for best and final offers. The request shall include the date, time, and place for the submission of best and final offers. Best and final offers shall be requested only once, unless the Administration makes a determination that it is advantageous to the state to conduct further discussions or change the state's requirements. The request for best and offers shall inform the offerors that if they do not submit a notice of withdrawal or a new offer, their immediate previous offer shall be construed as their best and final offer.
4. The Administration shall base proposal evaluation on the evaluation factors in the RFP.
5. The Administration shall provide written notice to offerors whose proposals are rejected. The rejection notice shall be made part of the contract file and public record.

D. Contract award.
1. In competitive counties, the Administration shall use the evaluation factors in the RFP to assess each proposal, and award a contract to the responsible and responsive offeror determined to be most advantageous to the state.
2. Counties required by law to be program contractors, and counties that have exercised the right of 1st refusal, shall submit to the Administration a satisfactory comprehensive plan for delivery of services in response to the RFP.
3. The contract file shall contain the basis on which the award is made. A contract shall not be awarded to any program contractor that will cause the System to lose any federal monies to which it is otherwise entitled.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3).

R9-28-605. Contract or Proposal Protests; Appeals

A. Resolution of proposal protests. The procurement officer issuing a RFP under R9-28-604 shall have the authority to resolve proposal protests. Appeal from the decision of the procurement officer may be made to the Director under subsection (G). This Section does not apply to contracting between the

Administration and the counties or the Arizona Department of Economic Security under A.R.S. § 36-2940.

B. Filing of a protest:
1. Any interested party may protest a RFP issued by the Administration, a proposed award, or an award of a contract by filing a protest with the procurement officer. "Interested party" means an actual or prospective offeror whose economic interest may be affected substantially and directly by the issuance of a request for proposals, the award of a contract, or the failure to award a contract. This Section does not apply to grievances related to contract performance. Grievances related to contract performance are governed by R9-28-803.
2. Content of protest. A protest shall be in writing and include the following information:
   a. The name, address, and telephone number of the protester;
   b. The signature of the protester or its representative;
   c. The request for proposals or contract number;
   d. The legal and factual grounds of the protest, including copies of relevant documents; and
   e. The relief requested.

C. Time for filing protests:
1. Protests concerning improprieties in a request for proposals. Protests based upon alleged improprieties in the request for proposals that are apparent before the submission deadline for initial proposals shall be filed before that submission deadline.
2. In cases other than those covered in subsection (C)(1), protests shall be filed within 10 days after the protester knows or should have known the basis of the protest, whichever is earlier.

D. Stay of procurements during the protest. If a protest is filed before the award of a contract, the award may be made, unless the Director makes a written determination that there is a reasonable probability the protest will be sustained and the stay of award of the contract is not contrary to the best interests of the state.

E. Decision by the procurement officer:
1. The procurement officer shall issue a written decision within 14 days after a protest has been filed. The decision shall contain an explanation of the basis of the decision.
2. The procurement officer shall furnish a copy of the decision to the protester, by certified mail, return receipt requested, or by any other method that provides evidence of receipt.
3. The time limit for decisions in subsection (E)(1) may be extended by the Director for a reasonable time not to exceed 30 days. The procurement officer shall notify the protester in writing that the time for issuance of a decision has been extended and the date by which a decision will be issued.
4. If the procurement officer fails to issue a decision within the time limit in subsections (E)(1) or (3), the protester may proceed as if the procurement officer had issued a decision adverse to the protester.

F. Remedies:
1. If the procurement officer sustains the protest in whole or part and determines that the request for proposals, proposed contract award, or contract award does not comply with applicable statutes and rules, the officer shall implement an appropriate remedy.
2. In determining an appropriate remedy, the procurement officer shall consider all of the circumstances surrounding the procurement or proposed procurement including the seriousness of the procurement deficiency, degree of prejudice to other interested parties or the integrity of the procurement system, good faith of the parties, extent of performance, costs to the state, urgency of the procurement, and impact of the relief on the Administration's mission.
3. A remedy shall be deemed appropriate if it includes 1 or more of the following:
   a. Decline to exercise an option to renew under the contract;
   b. Terminate the contract;
   c. Reissue the request for proposals;
   d. Issue a new request for proposals; or
   e. Award a contract consistent with procurement statutes and rules.

G. Appeals to the Director:
1. An appeal from a decision entered or deemed to be entered by the procurement officer shall be filed with the Director within 5 days from the date the decision is received. The appellant shall also file a copy of the appeal with the procurement officer.
2. Content of appeal. The appeal shall contain:
   a. The information in subsection (B);
   b. A copy of the decision of the procurement officer;
   c. The precise factual or legal error in the decision of the procurement officer from which the appeal is taken; and
   d. A request for hearing unless the appellant desires that the Director's decision be based solely upon the contract record as it then exists.

H. Stay of procurement during appeal. If a protect is filed before an award of contract and the award of the contract is stayed by the procurement officer under subsection (D), the filing of an appeal shall automatically continue the stay, unless the Director makes a written determination that award of the contract without delay is necessary to protect substantial interests of the state.

I. Dismissal before hearing. The Director shall dismiss, upon a written determination, an appeal before scheduling a hearing if:
1. The appeal does not state a valid basis for protest;
2. The appeal is untimely under subsection (G); or
3. The appeal is moot.

J. Hearing. Hearings requested under this rule shall be conducted as described in Article 8.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3).

R9-28-606. Contract Amendments; Mergers; Reorganizations

A. If there is a proposed merger, reorganization, or change in ownership of a program contractor, the program contractor shall submit details of the proposed merger, reorganization, or change in ownership to the Administration for prior written approval by the Director. Additionally, if there is a proposed merger, reorganization, or change in ownership of a provider (A.R.S. §§ 36-2931 and 36-2901) that is related to or affiliated with the program contractor, the program contractor shall submit the details of the proposed merger, reorganization, or change in ownership to the Administration for prior written approval by the Director.

B. In those counties where the county is not required by law to be the program contractor, the Administration shall deem amend-

ments to extend or modify the contract to have been accepted 60 days from the date of mailing by the Administration, even if the amendment has not been signed by the program contractor. If, within the 60 days, the program contractor notifies the Administration in writing that it refuses to sign the amendment, the Administration may initiate contract termination proceedings.

C. For counties and state agencies required by law to be a program contractor, the Administration shall deem amendments to extend or modify the contract to have been accepted 60 days from the date of mailing by the Administration, even if the amendment has not been signed by the mandated program contractor. If, within the 60 days, the program contractor notifies the Administration in writing that it refuses to sign the amendment, the disagreement will be considered a grievance and administered in accordance with Article 8.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3).

R9-28-607. Contract Sanctions

A. General. Grounds for suspending, denying, refusing, or failing to renew, or terminating a contract or subcontract, or imposing monetary sanctions shall include, but not be limited to, the reasons listed below:

1. Submitting any misleading, false, or fraudulent information with a claim for payment;
2. Submitting false information for the purpose of obtaining greater compensation than that to which the program contractor or provider is legally entitled;
3. Submitting inaccurate or incomplete representations in a proposal;
4. Failing to disclose or make available to the Administration, or its authorized representatives, records of services provided to eligible persons or members and records of payment;
5. Submitting false information for the purpose of obtaining authorization to provide services requiring authorization;
6. Over-providing services or delivering unnecessary services by inducing or otherwise causing an eligible person or member to receive services or items not required by the eligible person or member or by directly furnishing the services or items;
7. Providing any service in violation of, not authorized by, or which is otherwise precluded by law;
8. Breaching terms or conditions of a contract;
9. Having a member of the board, administrator, manager, or participating physician convicted of a felony;
10. Giving or accepting a rebate, kickback, fee, portion of a fee, or charge for referral of an eligible person or member;
11. Violating any of the provisions of A.R.S. Title 36, Chapter 29; Title XIX of the Social Security Act, as amended; or any state or federal rule promulgated thereunder;
12. Demonstrating an inability to perform contract obligations.
13. Having substantially breached a previous or existing contract agreement with another state agency;
14. Being previously found ineligible to participate in a federal or state assembled medical program by the Administration or any other state or federal governmental agency;
15. Failing to reimburse providers for medically necessary institutional and HCBS within 30 days of the receipt of valid, clean claims, unless a different period is specified by contract, or failing to ensure that future claims will be timely paid;
16. Failing to reimburse providers for medically necessary acute health care services within 60 days of receipt of valid, clean claims, unless a different period is specified by contract, or failing to ensure that future claims will be timely paid;
17. Failing to reimburse providers for emergency medical services within 60 days of receipt of valid, clean claims, or failing to ensure that future claims will be timely paid;
18. Failing to provide and maintain quality health care service to eligible persons and members, as determined by standards established by state and federal statutes;
19. Endangering the health, safety, or well-being of an eligible person or member, either by omission or commission.
20. Becoming insolvent, filing proceedings in bankruptcy or reorganization under the United States Code, or assigning rights or obligations under the contract without the prior written consent of the Administration;
21. Failing or refusing to comply with the reporting or disclosure requirements;
22. Committing fraud or abuse or having a provider that commits fraud or abuse;
23. Having any person who has an ownership or controlling interest in the program contractor or provider, or is an agent or managing employee of the program contractor or provider convicted of a criminal offense related to involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act;
24. Failing to conform to and abide by the applicable laws or rules of the state of Arizona, the United States Federal Government, and the Administration;
25. Failing to comply with the approved utilization review plan;
26. Having a suspended or revoked professional license;

B. Monetary sanctions. Monetary sanctions are imposed as follows:

1. Except as provided in subsection (B)(2), the Administration shall withhold a percentage of a program contractor's capitation payment, commensurate with the nature, term, and severity of the violation;
2. If a program contractor provides inappropriate services to an eligible person or member, the Administration shall withhold an amount equal to the cost of the services from the program contractor's capitation payment;
3. The Administration shall provide a written notice to a program contractor specifying the monetary sanction, grounds for the sanction, and either the length of suspension of payment or the amount of payment to be withheld; and
4. Nothing contained in this Section shall be construed to prevent the Administration from imposing sanctions provided for by contract.

C. Termination or suspension of a contract without cause. Termination or suspension of a contract, in whole or in part, without cause shall be effective 30 days after the Administration mails written notice of termination or suspension by certified mail, return receipt requested, to a program contractor.

D. The Administration shall apply remedies for nursing facilities that do not meet requirements of participation in accordance with Section 1919(h) of the Social Security Act, effective

December 19, 1989, and 42 CFR 488, Subpart F, September 28, 1995, incorporated by reference and on file with the Administration and the Office of the Secretary of State. These incorporations by reference contain no future editions or amendments.

E. Notification. The Director shall provide written notice of intent to suspend, refuse to renew, or terminate a contract or subcontract. The notice shall be provided to affected principals, enrolled members, and other interested parties and shall include the effective date of, and reason for, the action.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Amended effective August 11, 1997 (Supp. 97-3).

R9-28-608. Reserved

R9-28-609. Specialty contracts
The Director shall negotiate speciality contracts pursuant to A.A.C. R9-22-716.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that the amendment was not reviewed by the Governor's Regulatory Review Council; the agency did not submit a notice of proposed rulemaking for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rulemaking; and the Attorney General has not certified the rule.

R9-28-610. Hospital Rate Negotiations

A. Program contractors that negotiate with hospitals for inpatient services shall reimburse hospitals for patient care in accordance with R9-22-715(A).

B. If the Administration negotiates or contracts with hospitals on behalf of program contractors for discounted hospital rates, the negotiated discounted rates shall be included in contracts between program contractors and hospitals when in the best interest of the state.

C. The Director shall apportion any cost avoidance in the hospital component of provider capitation rates between the Administration and program contractor. The Administration's portion of the cost avoidance shall be reflected in reduced capitation rates paid to program contractors.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 1, 1993 (Supp. 93-1).

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-28-701. Scope of the Administration's liability

A. The Administration shall bear no liability for the provision of covered services or the completion of a plan of treatment to any member or eligible person beyond the date of termination of such individual's eligibility and enrollment.

B. The Administration shall bear no liability for subcontracts which the program contractor may execute with other parties for the provision of either administrative or management services, medical services, covered health care services or for any other purpose. The program contractor shall indemnify and hold the Administration harmless from any and all liability arising from these subcontracts and shall bear all costs of defense of any litigation over such liability and shall satisfy in full any judgment entered against the Administration in such connection.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3).

R9-28-702. Prohibition Against Charges to Members or Eligible Persons

A. A program contractor, provider, or noncontracting provider shall not charge, submit a claim, demand, or otherwise collect payment from a member or eligible person or a person acting on behalf of a member or eligible person for any covered service other than for a member's or eligible person's share of cost, authorized copayment, or payment for noncovered services. A program contractor shall have the right to recover from a member that portion of payment made by a 1st or 3rd party to the member when the payment duplicates ALTCS-paid benefits.

B. A program contractor, provider, or noncontracting provider shall not bill or make any attempt to collect payment, directly or through a collection agency, from an individual claiming to be ALTCS eligible without 1st receiving verification from the Administration that the individual was ineligible for ALTCS on the date of service, or that service provided was not covered by ALTCS, except as specified in subsection (A).

C. A program contractor, provider, or noncontracting provider may bill an eligible person or member for medical expenses incurred during a period of time when the individual willfully withheld material information pertaining to the individual's ALTCS eligibility or enrollment.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective September 22, 1997 (Supp. 97-3).

R9-28-703. Claims

A. Program contractors. All claims for covered services rendered to a member enrolled with a prepaid program contractor, shall be submitted to the program contractor.

B. Providers and noncontracting providers. A provider or noncontracting provider shall submit all claims for covered services rendered to an eligible person to the Administration for payment in accordance with A.A.C. R9-22-703 and this Article.

C. Timeliness. A program contractor, provider, or noncontracting provider shall ensure that a claim for covered services provided to a member or eligible person is initially received by the Administration no later than 9 months after the last date of service shown on the claim, or 9 months after the date of eligibility posting, whichever is later. The Administration shall not consider a claim for payment unless the claim is received by the Administration as a clean claim no later than 12 months after the last date of service shown originally on the claim, or 12 months after the date of eligibility posting, whichever is later.

1. Reinsurance claims shall be submitted to the Administration in accordance with A.A.C. R9-22-703.
2. The date of receipt of a claim is the date the Administration receives the claim. The Administration shall consider for payment only claims received in accordance with the provisions of this Section.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993

(Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3).

R9-28-704. Transfer of Payments

A. Payments permitted. In the following circumstances and when in the best interests of the state, the Administration or its contractors shall make payments to other than a program contractor, provider, or noncontracting provider:
1. When payment is in accordance with an assignment to a government agency or an assignment made under a court order; or
2. When payment is to a business agent, such as a billing service or accounting firm, that renders statements and receives payment in the name of the program contractor, noncontracting provider, or provider, providing that the agent's compensation for this service is:
   a. Reasonably related to the cost of processing the statements; and
   b. Not dependent upon the actual collection of payment.

B. When in the best interests of the state, the Administration or its contractors shall make payment to a primary care provider, dentist, or other health care professional as follows:
1. To the employer of the primary care provider, dentist, or other health professional, if the health care professional is required, as a condition of employment, to turn over fees to the employer;
2. To a foundation, plan, consortium, or other similar organization, including a health care service organization, that furnishes health care through an organized health care delivery system, if there is a contractual arrangement between the organization and the health care professional furnishing the services under which the organization bills or receives payment for the services.

C. Payments prohibited. A program contractor, provider, or noncontracting provider shall not assign all or part of ALTCS payments for covered services furnished to a member or eligible person to any party other than the program contractor, provider, or noncontracting provider except as specified in this Section.

D. Prohibition of payments to factors. A program contractor, provider, or noncontracting provider shall not make payment for covered services furnished to a member or eligible person to or through a factor, either directly, or by virtue of a power of attorney given to the factor.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective September 22, 1997 (Supp. 97-3).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that the amendment was not reviewed by the Governor's Regulatory Review Council; the agency did not submit a notice of proposed rulemaking for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rulemaking; and the Attorney General has not certified the rule. This Section was subsequently amended through the regular rulemaking process.

R9-28-705. Payments by Program Contractors

A. Authorization. A program contractor shall pay for all ALTCS covered services rendered to a member when the service or admission has been arranged by a program contractor's agent, an employee, a provider, or other individual acting on a program contractor's behalf, and for which necessary authorization has been obtained.

B. Timeliness of provider claim payment. A program contractor shall pay a claim or shall provide a notice for a denied or a reduced claim as specified in R9-22-705.

C. Payment for a long-term care service in an institutional and a home and community-based setting. A program contractor shall submit annually to the Administration, a program contractor's proposed payment methodology for reimbursement of a participating provider for long-term care services in an institutional and a home and community-based setting. All payment methods and rates of payment shall be subject to the approval of the Administration based on the reasonableness of the methods and rates. A program contractor shall use the following types of reimbursement:
1. The Administration's fee-for-service schedule;
2. Subcapitation;
3. Prospective payment when payment is tied to quality of care;
4. Volume purchase; and
5. Selective contracting and competitive bidding.

D. Payment for in-state medically necessary acute outpatient services. A program contractor shall reimburse an in-state provider and a noncontracting provider for the provision of medically necessary outpatient services to a program contractor's member.

E. Payment for acute inpatient hospital services and out-of-state hospital services. A program contractor shall reimburse a provider and a noncontracting provider for the provision of medically necessary inpatient hospital services to a program contractor's member.

F. Reimbursement standards for emergency services. A program contractor shall pay for all emergency care services rendered to a program contractor's member by a noncontracting provider or a provider when the services:
1. Are rendered according to the prudent layperson standard;
2. Conform to the definitions of emergency medical and acute mental health services defined in 9 A.A.C. 22, Article 1; and
3. Conform to the notification requirements in 9 A.A.C. 22, Article 2.

G. Transportation. A program contractor shall pay for ground or air ambulance transport in response to a 9-1-1 or other emergency response system call specified in R9-22-705.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective November 5, 1993 (Supp. 93-4). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1).

R9-28-706. Payments by the Administration for Services Provided to Eligible Persons

A. Payment for medically necessary outpatient services.
1. The Administration shall pay for medically necessary outpatient services provided to eligible persons from the effective date of eligibility to the date of enrollment with a program contractor at the negotiated rate, capped fee-for-service rate, or billed charges, whichever is lowest.
2. Eligible persons residing in areas that are not served by program contractors shall be eligible for ALTCS covered services. The Administration shall make payment for medically necessary outpatient services provided to these individuals at the negotiated rate, capped fee-for-service-rate, or billed charges, whichever is lowest.

3. The Administration shall pay for medically necessary outpatient services provided to eligible persons by out-of-state providers at the capped fee-for-service rate under R9-28-708 or the Medicaid rate that is in effect at the time services are provided in the state in which the provider is located, whichever is lower.

B. The Administration shall make payment in accordance with A.A.C. R9-22-712 for covered hospital services provided to eligible persons on or after March 1, 1993.

C. Limitation on payment for hospital services. The Administration may limit payment for hospital services furnished to hospital inpatients who require a lower covered level of care, such as nursing facility services, to the cost of the lower or alternative level of care, when the Director or designee determines the less costly alternative could and should have been used by a hospital.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsections (A) and (B) effective June 6, 1989 (Supp. 89-2). Amended effective April 25, 1990 (Supp. 90-2). Amended effective November 5, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that the amendment was not reviewed by the Governor's Regulatory Review Council; the agency did not submit a notice of proposed rulemaking for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rulemaking; and the Attorney General has not certified the rule. This Section was subsequently amended through the regular rulemaking process.

R9-28-707. Contractor's Liability to Hospitals for the Provision of Emergency and Subsequent Care

A. The program contractor is responsible for providing emergency medical or acute behavioral health care to a member only until the time the member's condition is stabilized and the member is transferable, or until the member is discharged following stabilization subject to the requirements of A.R.S. § 36-2909(B) and Article 2 of this Chapter.

B. Subject to subsection (A), if a member cannot be transferred following stabilization to a facility that has a subcontract with a program contractor, the program contractor shall pay for all treatment that is appropriately documented, medically necessary treatment, and prior authorized in accordance with A.A.C. R9-22-705, provided to the member before the date of discharge or transfer in accordance with payment standards in A.A.C. R9-22-705.

C. If a member refuses transfer from a noncontracting provider institution to an institution affiliated with the member's program contractor, neither the Administration nor the program contractor shall be liable for any costs incurred subsequent to the date of refusal when:

1. Subsequent to consultation with the member's program contractor, the member continues to refuse the transfer; and
2. The member is provided and signs a written statement, before the date of transfer of liability, informing the member of the medical and financial consequences of refusing to transfer. If the member refuses to sign the written statement, a statement signed by 2 witnesses indicating that the member was informed may be substituted.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective September 22, 1997 (Supp. 97-3).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that the amendment was not reviewed by the Governor's Regulatory Review Council; the agency did not submit a notice of proposed rulemaking for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rulemaking; and the Attorney General has not certified the rule. This Section was subsequently amended through the regular rulemaking process.

R9-28-708. Capped Fee-for-service Payment

A. Service codes. A current copy of the code manuals listed below shall be maintained on file at the central office of the Administration for reference use during customary business hours.

1. The Physicians' Current Procedural Terminology (CPT) and Health Care Financing Administration Common Procedures Coding System (HCPCS) shall be utilized to identify medical services and procedures performed by physicians and other providers.
2. The Code on Dental Procedures and Nomenclature, as published in the Journal of the American Dental Association, shall be utilized to identify dental procedures.
3. The International Classification of Diseases.
4. The American Druggist Blue Book.

B. Fee schedule. The Administration shall pay providers and noncontracting providers at the capped fee-for-service rates specified below unless a different fee is specified by contract or otherwise required by this Article. Notice of changes in methods and standards for setting payment rates for services shall be in accordance with 42 CFR 447.205, January 18, 1984, incorporated by reference herein and on file with the Office of the Secretary of State.

1. ALTCS services. Payment shall be in accordance with the lower of the negotiated rate or fee schedules which are on file at the central office of the Administration for reference during customary business hours.
2. Physician services. Payment shall be in accordance with fee schedules which are on file at the central office of the Administration for reference use during customary business hours.
3. Hospital services. Hospital services provided to eligible persons shall be paid pursuant to R9-22-712.
4. Pharmacy services. Payment shall be in accordance with fee schedules which are on file at the central office of the Administration for reference use during customary business hours. The maximum allowable rates under the fee schedules shall not exceed the payment levels established pursuant to 42 CFR 447.331 through 447.332, incorporated by reference herein and on file with the Office of the Secretary of State.
5. Dental services. Payment shall be in accordance with fee schedules which are on file at the central office of the Administration for reference use during customary business hours.
6. Transportation services. Payment for transportation services shall be made in accordance with A.A.C. R9-22-710.
7. Medical equipment. Payment for medical equipment shall be in accordance with fee schedules which are on

file at the central office of the Administration for reference use during customary business hours. Providers shall be reimbursed once for the durable medical equipment (DME) during any given two-year period, unless the Administration determines that DME replacement within that period is medically necessary for the member. Unless authorized by the Administration, no more than one repair and adjustment shall be reimbursed during any two-year period.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 26, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective November 5, 1993 (Supp. 93-4).

R9-28-709. Reinsurance

A. Program contractor acquired reinsurance. A program contractor may obtain reinsurance for coverage of services provided to members enrolled with the program contractor.

B. Administration reinsurance. For purposes of the Administration's reinsurance program, the insured entity shall be a program contractor.

1. Reimbursement of covered services shall be subject to a deductible as specified in contract. The deductible shall be reset at the beginning of each contract year and when a member changes program contractors. Allowable costs in excess of the deductible amount shall have a reinsurance percentage as specified in contract applied to calculate the reimbursement amount. Medicare and other 1st-and 3rd-party payments shall be deducted from allowable costs before calculating the reimbursement amount.
2. Acute inpatient and psychiatric facility services provided while a member is enrolled with a program contractor are covered services for purposes of reinsurance reimbursement.
3. Services reimbursed under the reinsurance benefit are subject to medical review by the Administration. Reimbursement may be denied, payment levels reduced, or financial sanctions imposed upon a program contractor when medical review results in identification of services that could have been provided in a less costly, medically appropriate manner. Medical review and resulting adjustments to reimbursement shall be in accordance with contract.
4. Inpatient encounter data submitted by a program contractor shall be used by the Administration to identify reinsurance cases that exceed the deductible amounts and are subject to reimbursement.
5. A program contractor shall make available to the Administration upon request documentation to support:
   a. The services provided;
   b. The reimbursement for those services; and
   c. Attempts to recover the cost of those services from other payors.
6. The Administration may require contractual terms that prescribe special reinsurance requirements for catastrophic cases. The requirements may include:
   a. Conditions under which a case is considered catastrophic;
   b. Claim and documentation requirements; and
   c. The method and amount of reimbursement for catastrophic cases.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsection (B) effective June 6, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3).

R9-28-710. Capitation Payments to Program Contractors

A. The Administration shall make all payments to a program contractor in accordance with the terms and conditions of the contract executed between the program contractor and the Administration and this Chapter.

B. The Administration shall pay capitation monthly to a program contractor who has met the requirements in A.R.S. § 36-2942(8).

C. The Administration shall pay a program contractor a capitated amount per member per month. Administrative costs shall be incorporated into the capitation payment amount.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsections (C) and (D) effective June 6, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3).

R9-28-711. Payments Made on Behalf of a Program Contractor; Recovery of Funds; Postpayment Reviews

A. The Administration may make payments on behalf of a program contractor and may recover funds from a program contractor or provider in accordance with standards in A.A.C. R9-22-713. For purposes of this Section, the term "contractor" as it appears in A.A.C. R9-22-713 means "program contractor".

B. The Administration shall conduct postpayment reviews of claims paid by the Administration and shall recoup any monies erroneously paid. Program contractors may conduct postpayment reviews of claims paid by program contractors and may recoup any monies erroneously paid.

Historical Note
Adopted effective November 5, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3).

R9-28-712. County of Fiscal Responsibility

A. General requirements.

1. The Administration shall determine the county of fiscal responsibility to determine which program contractor is responsible for an elderly or physically disabled applicant (applicant) or an elderly or physically disabled member (member).
2. A program contractor shall cover services and provisions specified in 9 A.A.C. 22, Articles 2 and 7.

B. Criteria for determining county of fiscal responsibility for an applicant.

1. The county of fiscal responsibility is the county where the applicant resides if:
   a. The applicant resides in the applicant's own home as specified in R9-28-101(B)(16),
   b. The applicant moved from another state within the last 30 days, or
   c. The applicant has continuously resided in the current county 30 days immediately before entering:
      i. An alternative HCBS setting as specified in R9-28-101(B)(3),
      ii. A NF as specified in R9-22-101(B)(27), or
      iii. An intermediate care facility for the mentally retarded as specified in R9-28-101(B)(18).
2. The county of fiscal responsibility is the county where the applicant resides, whether in an alternative HCBS setting, or a NF, or an intermediate care facility for the

mentally retarded, 30 days immediately before moving to another county.

C. No change in the county of fiscal responsibility. The county of fiscal responsibility for a member shall remain the same if:
1. The member moves from a NF to another NF in a different county,
2. The member moves from a NF to an alternative HCBS setting in a different county,
3. The member moves from an alternative HCBS setting to another alternative HCBS setting in a different county,
4. The member moves from an alternative HCBS setting to a NF in a different county,
5. The member moves from the member's own home to an alternative HCBS setting in a different county, or
6. The member moves from the member's own home to a NF in a different county.

D. Change in the county of fiscal responsibility. If the member moves from 1 county to another, the county of fiscal of responsibility shall change to the new county if the member moves from:
1. An alternative HCBS setting to the member's own home in a different county,
2. A NF to the member's own home in a different county,
3. An intermediate care facility for the mentally retarded to the member's own home in a different county, or
4. The member's own home to the member's own home in a different county.

E. Transfers between program contractors. The Administration may transfer a member from 1 program contractor to a different program contractor if:
1. Both program contractors agree, or
2. The Administration determines it is in the best interest of the member.

F. No program contractor. If there is no authorized program contractor within the member's service area, the member shall receive services according to A.R.S. § 36-2945.

G. Arizona State Hospital (ASH). If the member moves from ASH to an approved ALTCS setting, the Administration shall assign the member to a program contractor in the county that the member resided in prior to admission in ASH. This subsection does not apply when a member moves from ASH to a member's own home.

Historical Note
Adopted effective November 4, 1998 (Supp. 98-4).

ARTICLE 8. GRIEVANCE AND APPEAL PROCESS

R9-28-801. General Provisions for All Grievances and Appeals

All grievances and appeals regarding ALTCS shall be filed and processed in accordance with A.A.C. R9-22-801, and all references in that rule to AHCCCS also shall apply to ALTCS. In eligibility appeals, ALTCS is the respondent.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective August 11, 1997 (Supp. 97-3).

R9-28-802. Eligibility Appeals and Hearing Requests for Applicant or Recipients of ALTCS

A. Adverse eligibility actions. An applicant, eligible person, or member may appeal and request a hearing concerning any of the following adverse eligibility actions:
1. Denial of eligibility;
2. Discontinuance of eligibility;
3. Delay in the eligibility determination;
4. Adverse post-eligibility treatment of income; or
5. Adverse disability determination.

B. The Administration shall provide notice of an adverse eligibility action to the affected individual by personal delivery or regular mail. For purposes of this Section, the date of the Notice of Adverse eligibility action shall be the date of personal delivery to the individual or the postmark date, if mailed.

C. Appeals and requests for hearing.
1. An applicant, eligible person, member, or authorized representative may appeal and request a hearing regarding any adverse eligibility action by completing and submitting the ALTCS Request for Hearing form or by submitting a written request containing the following information:
   a. The case name,
   b. The adverse eligibility action being appealed, and
   c. The reason for appeal.
2. The request for hearing shall be submitted within 20 days of a notice of denial or 10 days after the effective date of all other adverse actions by mailing or delivering it to either the eligibility office that rendered the adverse decision or directly to the Administration, Office of Grievance and Appeals. For this Section only, the date of the request for hearing shall be the postmark date, if mailed, or the date of personal delivery.

D. Eligibility office responsibilities.
1. Eligibility offices shall maintain a register that documents the dates on which ALTCS Requests for Hearing are submitted.
2. If requested, an eligibility office shall help an appellant or authorized representative to complete the ALTCS Request for Hearing form.
3. The prehearing summary shall be completed by the eligibility office and shall summarize the facts and factual basis for the adverse eligibility action.
4. The eligibility office shall send to the Administration, Office of Grievance and Appeals:
   a. The prehearing summary;
   b. A copy of the case file;
   c. Documents pertinent to the adverse action; and
   d. The request for hearing. These materials must be received by the Administration, Office of Grievance and Appeals, not later than 10 days from the date of the receipt of the request for hearing. If the request for hearing is submitted directly to the Administration, Office of Grievance and Appeals, the eligibility office shall send the materials to the Office of Grievance and Appeals, not later than 10 days from the date of a request for the materials.

E. ALTCS coverage during the appeal process.
1. Eligible persons or members appealing a discontinuance. A discontinuance is a termination of ALTCS benefits. For actions requiring 10 days' advance notice, an eligible person or member requesting a hearing before the effective date of the adverse action shall receive continued ALTCS benefits until an adverse decision on appeal is rendered.
2. Applicants appealing a denial of ALTCS coverage:
   a. A denial is an adverse eligibility decision that finds an applicant ineligible for ALTCS benefits.
   b. An applicant may appeal a denial within the timeframe specified in subsection (C)(2). If the denial is overturned, the effective date of ALTCS coverage shall be established by the Director in accordance with applicable law.

3. An eligible person or member whose benefits are continued under subsection (E)(1) may be financially liable for all ALTCS benefits received during a period of ineligibility, if a discontinuance decision is upheld by the Director.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective August 11, 1997 (Supp. 97-3).

R9-28-803. Grievances

All grievances regarding ALTCS shall be filed and processed in accordance with A.A.C. R9-22-804, and all references in that rule to AHCCCS also shall apply to ALTCS.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Section repealed; new Section adopted effective August 11, 1997 (Supp. 97-3).

R9-28-804. Repealed

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Section repealed effective August 11, 1997 (Supp. 97-3).

ARTICLE 9. 1ST- AND 3RD-PARTY LIABILITY AND RECOVERIES

R9-28-901. 1st- and 3rd-Party Liability and Coordination of Benefits

General Provisions. The provisions in A.A.C. R9-22-1001 apply to this Section.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 7, 1997 (Supp. 97-4).

Editor's Note: The following Section was amended under an exemption from the rulemaking provisions of the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6, §§ 1001 et seq.). Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Governor's Regulatory Review Council did not review these rules; AHCCCS was not required to hold public hearings on these rules; and the Attorney General has not certified these rules. This Section was subsequently amended under the regular rulemaking process (Supp. 97-4).

R9-28-902. 1st- and 3rd-Party Liability Monitoring and Compliance

General provisions. The provisions in A.A.C. R9-22-1002 apply to this Section.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended effective November 7, 1997 (Supp. 97-4).

R9-28-903. Reserved

R9-28-904. Reserved

R9-28-905. Reserved

R9-28-906. Recoveries

A. The Administration may recover funds paid for ALTCS benefits including: capitation payments, Medicare Parts A and B premium payments, coinsurance, deductibles, fee-for-service, and any other payments made by the Administration for a member or eligible person from:

1. The estate of the member or eligible person who was 55 years of age or older when the member or eligible person received benefits; or
2. The estate or the property of the member or eligible person according to A.R.S. §§ 36-2935 and 36-2956 and 42 U.S.C. 1396(p), October 1, 1993, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. The Administration may waive or compromise the recovery of funds when the recovery would cause an undue hardship to a surviving heir of the member or eligible person. In making the undue hardship decision, the Administration will consider the following:

1. When estate assets include real property or both real and personal property. There is property in the estate, and the property is listed as residential property by the Arizona Department of Revenue or County Assessor's Office, and the heir:
   a. Owns a business that is located at the residential property, and
      i. The business was in operation at the residential property for at least 12 months preceding the death of the member or eligible person;
      ii. The business provides more than 50% of the heir's livelihood; and
      iii. The recovery of the property would result in the heir losing the heir's means of livelihood; or
   b. Currently resides in the residence, and
      i. Resided there at the time of the member's or eligible person's death;
      ii. Made the residence his or her primary residence for the 12 months immediately preceding the death of the member or eligible person; and
      iii. Owns no other residence.
2. When the estate assets contain personal property only.
   a. The heir's annual gross income for the household size is within 100% of the Federal Poverty Level (FPL). New sources of income (for example, employment, Social Security), which may not have yet been received, will be included in determining the household's annual gross income; and
   b. The heir does not own a home, land, or other real property.

C. If the heir's circumstances meet the conditions in subsections (B)(1) or (B)(2), the Administration shall determine on a case-by-case basis, to what extent, if any, the claim will be compromised or waived. Factors in making this determination include:

1. Financial and medical hardship to the heir if a compromise or waiver is not granted;
2. Income of the heir and whether the heir's household's gross annual income is within 100% of the FPL;
3. Resources of the surviving heir;
4. Value and type of assets in the estate (real and personal);

5. Amount of the Administration's claim against the estate; and
6. Whether other creditors have filed claims against the estate or have foreclosed on the property.

D. A promissory note and deed of trust may be required in cases where a claim against property is compromised or waived, and the heir resides in the residence, maintains a business at the residence, or otherwise relies on the residence for support and means of livelihood. Within 30 days of receiving an undue hardship decision notice from the Administration, the executor of the estate or heir shall secure a promissory note and deed of trust, and provide certified copies to the Administration. The heir shall bear the costs for securing these documents.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 7, 1997 (Supp. 97-4).

ARTICLE 10. CIVIL MONETARY PENALTIES AND ASSESSMENTS

R9-28-1001. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims
The Director or designee shall impose a penalty and assessment under the circumstances described in A.R.S. § 36-2957. The Administration shall use the procedures detailed in 9 A.A.C. 22, Article 11 for the determination and collection of civil penalties and assessments.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective June 9, 1998 (Supp. 98-2).

R9-28-1002. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Repealed effective June 9, 1998 (Supp. 98-2).

R9-28-1003. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Repealed effective June 9, 1998 (Supp. 98-2).

R9-28-1004. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Repealed effective June 9, 1998 (Supp. 98-2).

ARTICLE 11. BEHAVIORAL HEALTH SERVICES

Editor's Note: The following Section was adopted under an exemption from the rulemaking provisions of the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6, §§ 1001 et seq.). Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Governor's Regulatory Review Council did not review these rules; AHCCCS was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-28-1101. Definitions
The definitions set forth in A.A.C. R9-28-101 and R9-22-1201 apply to terminology in this Article. Where definitions under these rule sections may conflict, the definitions set forth in R9-28-101 are applicable.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4).

Editor's Note: The following Section was adopted and amended under an exemption from the rulemaking provisions of the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6, §§ 1001 et seq.). Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Governor's Regulatory Review Council did not review or approve these rules; and AHCCCS was not required to hold public hearings on these rules.

R9-28-1102. Eligibility
Persons with a behavioral health or substance abuse disorder and eligible pursuant to A.R.S. § 36-2931(5) shall be eligible for covered behavioral health services set forth in R9-28-1104.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Office of the Secretary of State September 29, 1995 (Supp. 95-4).

Editor's Note: The following Section was adopted and amended under an exemption from the rulemaking provisions of the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6, §§ 1001 et seq.). Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Governor's Regulatory Review Council did not review or approve these rules; and AHCCCS was not required to hold public hearings on these rules.

R9-28-1103. Service Delivery System
Program contractors, including the Administration for counties in which there is no program contractor, shall be responsible for the provision of medically necessary behavioral health services set forth under this Article to members.

1. Program contractors shall determine if members need behavioral health services and, if determined to be medically necessary, arrange for behavioral health services set forth in R9-28-1104.
2. Program contractors shall ensure the provision of covered services through the direct provision of services (if the Administration grants a waiver pursuant to A.R.S. 36-2940(A)) or through contracts or agreements with qualified providers.
3. Program contractors may contract with a Regional Behavioral Health Authority (RBHA) which will be responsible for the provision of behavioral health services through its service provider network.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Office of the Secretary of State September 29, 1995 (Supp. 95-4).

Editor's Note: The following Section was adopted and amended under an exemption from the rulemaking provisions of the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6, §§ 1001 et seq.). Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Governor's Regulatory Review Council did not review or approve these rules; and AHCCCS was not required to hold public hearings on these rules.

R9-28-1104. ALTCS-covered Behavioral Health Services

A. The following general service requirements apply with respect to behavioral health services provided under this Article, subject to all applicable exclusions and limitations set forth in this Article:
1. The service shall be medically necessary, cost effective, and Title XIX reimbursable.
2. The service shall be provided by qualified service providers pursuant to R9-28-1105.
3. Services shall be authorized, as applicable, by the program contractor and shall be consistent with prior authorization, federal certification of need and inspection of care requirements and utilization review standards established by the Director.
4. The person is eligible for Title XIX on the date the service is provided and is not a resident in an institution for mental diseases (MD), unless the member or eligible person is under 21 years of age and in a Title XIX participating inpatient psychiatric facility, or 65 years of age and older and in a Title XIX participating IMD.
5. Services shall be provided in appropriate residential settings which meet state and federal licensing standards and which are allowable under A.R.S. § 36-2939.

B. The following behavioral health services shall be covered, subject to the limitations and exclusions in this Article and further subject to approval by the Health Care Financing Administration.
1. Inpatient services, including:
   a. Inpatient hospital services for treatment of acute episodes, generally of a short duration, in participating acute general hospitals.
   b. Inpatient psychiatric facility services under the direction of a psychiatrist, for persons under 21 years of age in a residential treatment center (RTC) or an inpatient psychiatric hospital accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or an inpatient psychiatric hospital.
   c. IMD services for persons 65 years of age and older.
   d. Limitations:
      i. Inpatient substance abuse services initially may be authorized for up to 4 days of medically necessary detoxification. If medically necessary, additional days subsequently may be authorized if ordered by a physician and approved by the program contractor's Medical Director or the Administration.
      ii. Room and board is not a covered service in residential settings except for inpatient services set forth in subsection (B)(1).
2. Professional services, including:
   a. Individual therapy and counseling provided by a behavioral health professional or a behavioral health technician in face-to-face interaction with the member or eligible person.
   b. Group and/or family therapy/counseling provided by a behavioral health professional or a behavioral health technician in face-to-face interaction with the member or eligible person and his or her family, and/or spouse or other group.
   c. Limitations: Only psychiatrists and psychologists may bill independently for services provided. Other behavioral health professionals and behavioral health technicians shall be affiliated with qualified agencies such as a rehabilitation or clinic agency or hospital, and services provided by these individuals shall be billed through that agency.
3. Rehabilitation services, including:
   a. Basic partial care services which are provided by a behavioral health technician following residential or inpatient treatment, or to prevent placement in a more restrictive setting. Basic partial care services are provided within a structured, coordinated, and continuous program of goal-oriented therapeutic activities.
   b. Intensive partial care services which are provided by a behavioral health professional or a behavioral health technician as an alternative to inpatient care for members or eligible persons who are developmentally disabled. Intensive partial care services are a planned, structured, and coordinated program of intensive care which is scheduled for a minimum of 3 consecutive hours on a regular basis, providing active treatment for full or partial resolution of the member's or eligible person's acute or episodic behavioral health problems and includes on-site visits with a psychiatrist.
   c. Emergency/crisis behavioral health services provided by a behavioral health professional or a behavioral health technician. Such services are immediate and intensive, time-limited, community-based, face-to-face crisis interventions and resolution services available on a 24-hour basis in situations where a member or eligible person is a danger to self or others.
   d. Behavior management services provided by a behavioral health professional or a behavioral health technician. Behavior management services primarily involve direct patient behavior management for home and community-based services and may also include services related to activities of daily living and household services incidental to and consistent with the behavioral health rehabilitation needs of the member or eligible person.
4. Evaluation services provided by a behavioral health professional or a behavioral health technician. Evaluation services include the assessment of the member's or eligible person's psychiatric, psychological, or social conditions to determine if a mental disorder exists and, if so, to provide diagnosis for the direction of care.
5. Behavioral health-related services, including:

a. Psychotropic medications defined by the program contractor Title XIX formulary.

b. In addition to the behavioral health services covered in subsection (B), the covered services set forth in R9-28-202 shall incorporate behavioral health needs as appropriate.

6. Limitations:

a. Intensive partial care services shall be limited to members or eligible persons whose emotional, behavioral, or substance abuse problems indicate a serious emotional disturbance and/or evidence of abuse or neglect.

b. Prevocational or vocational activities and school attendance educational hours are not included in intensive and basic partial care services and shall not be billed simultaneously with these services.

c. Emergency/crisis behavioral health services are limited to emergencies or crises as defined in R9-22-101.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993; amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective January 1, 1996; filed with the Office of the Secretary of State December 22, 1995 (Supp. 95-4).

Editor's Note: The following Section was adopted and amended under an exemption from the rulemaking provisions of the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6, §§ 1001 et seq.). Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Governor's Regulatory Review Council did not review or approve these rules; and AHCCCS was not required to hold public hearings on these rules.

R9-28-1105. Qualifications and Standards of Participation for Service Providers

To provide behavioral health services to members or eligible persons, service providers shall comply with requirements set forth in R9-22-1205.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Office of the Secretary of State September 29, 1995 (Supp. 95-4).

Editor's Note: The following Section was adopted and amended under an exemption from the rulemaking provisions of the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6, §§ 1001 et seq.). Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Governor's Regulatory Review Council did not review these rules; AHCCCS was not required to hold public hearings on these rules; and the Attorney General has not certified these rules.

R9-28-1106. Payments

All payments to program contractors shall be made pursuant to the terms and conditions of agreements executed with the Administration in accordance with the requirements set forth in A.A.C. Title 9, Chapter 28, Article 7, unless otherwise specified in this Article.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3).

ARTICLE 12. MEMBERS' RIGHTS AND RESPONSIBILITIES

R9-28-1201. Rights and Responsibilities

The Administration and its contractors shall meet the requirements specified in 9 A.A.C. 22, Article 13.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).

TITLE 9. HEALTH SERVICES

CHAPTER 29. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM QUALIFIED MEDICARE BENEFICIARY (QMB)

ARTICLE 1. DEFINITIONS

Section
R9-29-101. Definitions

ARTICLE 2. ELIGIBILITY AND ENROLLMENT

Section
R9-29-201. General Provisions of QMB Eligibility
R9-29-202. QMB Enrollment
R9-29-203. QMB Discontinuance
R9-29-204. Repealed

ARTICLE 3. COVERED BENEFITS AND SERVICES

Section
R9-29-301. Qualified Medicare Beneficiary Only
R9-29-302. Qualified Medicare Beneficiary with Dual Eligibility

ARTICLE 4. CONTRACTOR, PROVIDER, NONPROVIDER, AND NONCONTRACTING PROVIDER REQUIREMENTS

Section
R9-29-401. Contractor, Provider, Nonprovider, and Noncontracting Provider Requirements
R9-29-402. Repealed
R9-29-403. Repealed
R9-29-404. Repealed

ARTICLE 5. GRIEVANCE AND APPEAL PROCESS

Section
R9-29-501. General Provisions for All Grievance and Appeals
R9-29-502. Eligibility Appeals and Hearing Requests for Applicants or Recipients of QMB Services
R9-29-503. Grievances
R9-29-504. Repealed

ARTICLE 6. 1ST- AND 3RD-PARTY LIABILITY AND RECOVERIES

Section
R9-29-601. 1st- and 3rd-Party Liability and Coordination of Benefits
R9-29-602. 1st- and 3rd-Party Liability Monitoring and Compliance

ARTICLE 1. DEFINITIONS

R9-29-101. Definitions

The following words and phrases, in addition to definitions contained in A.R.S. § 36-2971, have the following meanings unless the context of the Chapter explicitly requires another meaning:

1. "1st-party liability" has the meaning in 9 A.A.C. 22, Article 1.
2. "3rd party" has the meaning in 9 A.A.C. 22, Article 1.
3. "3rd-party liability" has the meaning in 9 A.A.C. 22, Article 1.
4. "AHCCCS" has the meaning in 9 A.A.C. 22, Article 1.
5. "ALTCS" means the Arizona Long-Term Care System as authorized by A.R.S. § 36-2931 et seq.
6. "CFR" means the Code of Federal Regulations.
7. "Contractor" has the meaning in 9 A.A.C. 22, Article 1.
8. "Dual eligible" has the meaning in A.R.S. § 36-2971.
9. "Enrollment" has the meaning in 9 A.A.C. 22, Article 1.
10. "Program contractor" has the meaning in A.R.S. § 36-2971.
11. "QMB-only" means Qualified Medicare Beneficiary only and is defined in A.R.S. § 36-2971.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective June 16, 1992 (Supp. 92-2). Amended effective April 14, 1998 (Supp. 98-2).

ARTICLE 2. ELIGIBILITY AND ENROLLMENT

R9-29-201. General Provisions of QMB Eligibility

A. The Administration shall process applications and determine eligibility in accordance with 42 U.S.C. § 1396d(p) August 5, 1997, and 42 CFR 435, Subpart J, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. Eligibility for QMB benefits becomes effective the 1st day of the month following the month in which an eligibility decision is made.

C. In accordance with A.R.S. § 36-2903.03, an individual shall be a U.S. citizen or have qualified alien status to be eligible for QMB benefits.

D. All QMB members shall be residents of Arizona in accordance with 42 CFR 435.403, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2).

R9-29-202. QMB Enrollment

Dual eligibles shall be enrolled or remain enrolled with the health plan, program contractor, or fee-for-service network in accordance with the provisions specified in 9 A.A.C. 22 and 9 A.A.C. 28.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective June 16, 1992 (Supp. 92-2). Section repealed; new Section adopted effective April 14, 1998 (Supp. 98-2).

R9-29-203. QMB Discontinuance

A. The Administration shall provide notice of discontinuance in accordance with 42 CFR 431.210, 431.211, 431.213, and 435.919 to members who become ineligible for QMB benefits, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. The Administration shall discontinue immediately and without notice members who lose QMB eligibility due to death; discontinuance shall be effective the day after the date of death.

C. A member shall lose QMB eligibility due to incarceration and shall be discontinued the date the Administration is notified.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Section repealed; new Section adopted effective April 14, 1998 (Supp. 98-2).

R9-29-204. Repealed

Historical Note
Adopted effective May 23, 1990 (Supp. 90-2). Repealed effective April 14, 1998 (Supp. 98-2).

ARTICLE 3. COVERED BENEFITS AND SERVICES

R9-29-301. Qualified Medicare Beneficiary Only

A. A person determined eligible as a QMB-only may receive the following benefits and services:
1. Payment of Medicare Part A premiums, coinsurance, and deductibles;
2. Payment of Medicare Part B premiums, coinsurance, and deductibles; and
3. Medicare-covered services defined in 42 CFR 409 and 410.

B. A person determined eligible as a QMB-only who receives covered services from a provider that does not accept Medicare assignment is entitled to coverage of the coinsurance and deductible up to and not exceeding the Medicare-approved amount. The AHCCCS Administration shall make payment of the coinsurance and deductible for a QMB-only member only to the provider. Under no circumstances shall the AHCCCS Administration make a coinsurance or deductible payment to a QMB-only member. The QMB-only member is responsible for any balance due to the provider after reimbursement of the applicable coinsurance and deductible by the AHCCCS Administration. The AHCCCS Administration shall have no liability for any balance.

Historical Note
Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2).

R9-29-302. Qualified Medicare Beneficiary with Dual Eligibility

A. A person determined dual eligible may receive the following benefits and services:
1. The benefits and services described in R9-29-301; and
2. Medical services and provisions in 9 A.A.C. 22, Article 2, subject to the specified limitations and exclusions or services and provisions in 9 A.A.C. 28, Article 2, subject to the specified limitations and exclusions.

B. The AHCCCS Administration may deny payment for covered benefits and services if:
1. The services are not obtained within the member's health plan or program contractor or fee-for-service network; or
2. The services are not provided in conformance with the provisions in 9 A.A.C. 22 or 9 A.A.C. 28.

C. A person determined dual eligible who receives covered services from a provider within the health plan, program contractor, or fee-for-service network shall not be liable for any coinsurance or deductibles associated with those services.

Historical Note
Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2).

ARTICLE 4. CONTRACTOR, PROVIDER, NONPROVIDER, AND NONCONTRACTING PROVIDER REQUIREMENTS

R9-29-401. Contractor, Provider, Nonprovider, and Noncontracting Provider Requirements

A. Contractors and other providers shall be responsible for providing the covered services specified in R9-29-302 to dual eligible and QMB-only members as specified in 9 A.A.C. 22.

B. Program contractors and other providers shall be responsible for providing the covered services specified in R9-29-302 to dual eligible and QMB-only members as specified in 9 A.A.C. 28.

C. Nonproviders and noncontracting providers shall submit all claims for services rendered to a dual eligible and QMB-only member including claims for copayments, as specified in A.R.S. § 36-2904(H).

D. The Administration or a Medicare risk contractor shall be responsible for recoupment of funds as specified in contract.

Historical Note
Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2).

R9-29-402. Repealed

Historical Note
Adopted effective May 23, 1990 (Supp. 90-2). Repealed effective April 14, 1998 (Supp. 98-2).

R9-29-403. Repealed

Historical Note
Adopted effective May 23, 1990 (Supp. 90-2). Repealed effective April 14, 1998 (Supp. 98-2).

R9-29-404. Repealed

Primary care physicians (PCPS) who are obstetricians or gynecologists shall only be PCPs for pregnant females.

Historical Note
Adopted effective May 23, 1990 (Supp. 90-2). Repealed effective April 14, 1998 (Supp. 98-2).

ARTICLE 5. GRIEVANCE AND APPEAL PROCESS

R9-29-501. General Provisions for All Grievances and Appeals

All grievances and appeals regarding QMB shall be filed and processed as specified in A.A.C. R9-22-801.

Historical Note
Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2).

R9-29-502. Eligibility Appeals and Hearing Requests for Applicants or Recipients of QMB Services

A. An individual affected by an adverse eligibility action may appeal and request a hearing concerning any of the following adverse eligibility actions:
1. Denial of eligibility;
2. Discontinuance of eligibility; or
3. Delay in the eligibility determination.

B. Notice of an adverse eligibility action shall be personally delivered or mailed to the affected individual by regular mail. For purposes of this Section, the date of the Notice of Action shall be the date of personal delivery to the individual or the postmark date, if mailed.

C. Appeals and requests for hearing.
1. An applicant, eligible person, or authorized representative may appeal and request a hearing from an adverse eligibility action by completing and submitting, no later than 35 days after the date of the Notice of Action, the AHCCCS request for hearing form, or a written request that contains the following information:
   a. The case name;
   b. The adverse eligibility action being appealed; and
   c. The reason for appeal.
2. The request for hearing shall be submitted to the Office of Grievance and Appeals, AHCCCS Administration. If the request for hearing is submitted by mail, the date of request shall be the postmark date. If the request for hear-

ing is submitted in person, the date of the request shall be the date on which the request is submitted to the Office of Grievance and Appeals.

D. Eligibility office responsibilities.

1. If requested, the eligibility office shall assist the individual or authorized representative to complete the request for hearing.
2. The eligibility office shall send to the AHCCCS Office of Grievance and Appeals the Pre-Hearing Summary and documents pertinent to the denial or discontinuance action within 5 days after the date of receipt of a request for materials from the AHCCCS Office of Grievance and Appeals.
3. The eligibility office shall complete and send to the AHCCCS Office of Grievance and Appeals with the Pre-Hearing Summary a summary of the factual basis for the adverse eligibility action.

E. Eligibility and benefits during the appeal process.

1. Individuals appealing a discontinuance. A discontinuance is a termination of eligibility and benefits. An individual requesting a hearing within the time-frame specified in subsection (C) shall continue to be eligible and receive benefits until an adverse decision on appeal is rendered.
2. Individuals appealing a denial of eligibility.
   a. A denial is an adverse eligibility decision that finds an applicant ineligible as a Qualified Medicare Beneficiary.
   b. The effective date of a denial is the date of notice of an adverse action. An individual may appeal this denial within the time-frame specified in subsection (C). If the denial is overturned, the effective date of eligibility shall be established by the Director in accordance with federal and state law.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2).

R9-29-503. Grievances

All grievances regarding QMB shall be filed and processed as specified in A.A.C. R9-22-804.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2).

R9-29-504. Repealed

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Repealed effective April 14, 1998 (Supp. 98-2).

ARTICLE 6. 1ST- AND 3RD-PARTY LIABILITY AND RECOVERIES

R9-29-601. 1st- and 3rd-Party Liability and Coordination of Benefits

A. The provisions specified in A.A.C. R9-22-1001 apply to this Section.

B. The Administration shall not be liable for payment of coinsurance and deductibles when Medicare denies payment.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2).

R9-29-602. 1st-and 3rd-Party Liability Monitoring and Compliance

The provisions in A.A.C. R9-22-1002 apply to this Section.

Historical Note

Adopted effective May 23, 1990 (Supp. 90-2). Amended effective April 14, 1998 (Supp. 98-2).

TITLE 9. HEALTH SERVICES

CHAPTER 30. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - PREMIUM SHARING DEMONSTRATION PROJECT

(Authority: A.R.S. § 36-2923 et seq.)

Editor's Note: This Chapter contains rules which were adopted and amended under an exemption from the certain provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to Laws 1997, Ch. 186, § 7. Exemption from A.R.S. Title 41, Chapter 6 means that the Arizona Health Care Cost Containment System did not submit these rules to the Governor's Regulatory Review Council for review and approval; and they did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register. Under Laws 1997, Ch. 186, § 7, AHCCCS was required to hold at least two public hearings before adopting this Chapter. Because this Chapter contains rules which are exempt from the regular rulemaking process, it is being printed on blue paper.

ARTICLE 1. DEFINITIONS

Section
R9-30-101. Location of Definitions
R9-30-102. Scope of Services Related Definitions
R9-30-103. Eligibility and Enrollment Related Definitions
R9-30-104. Reserved
R9-30-105. Reserved
R9-30-106. Grievance and Appeals Related Definitions
R9-30-107. Payment Responsibilities Related Definitions

ARTICLE 2. SCOPE OF SERVICES

Section
R9-30-201. General Requirements
R9-30-202. Reserved
R9-30-203. Reserved
R9-30-204. Inpatient General Hospital Services
R9-30-205. Primary Care Provider Services
R9-30-206. Organ and Tissue Transplantation Services for a Chronically Ill Member
R9-30-207. Dental Services
R9-30-208. Laboratory, Radiology, and Medical Imaging Services
R9-30-209. Pharmaceutical Services
R9-30-210. Emergency Medical Services and Emergency Behavioral Health Services
R9-30-211. Transportation Services
R9-30-212. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices
R9-30-213. Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)
R9-30-214. Reserved
R9-30-215. Other Medical Professional Services
R9-22-216. Nursing Facility Services
R9-30-217. Behavioral Health Services

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

Section
R9-30-301. General Requirements
R9-30-302. Time-frames for Determining Eligibility
R9-30-303. Conditions of Eligibility
R9-30-304. Enrollment
R9-30-305. Disenrollment
R9-30-306. Redetermination

ARTICLE 4. CONTRACTS

Section
R9-30-401. General Provisions
R9-30-402. Reserved
R9-30-403. PSA's Contracts with Contractors
R9-30-404. Subcontracts
R9-30-405. Contract Records
R9-30-406. Mergers; Reorganizations; Change in Ownership; and Contract Amendments
R9-30-407. Suspension; Modification; or Termination of Contract
R9-30-408. Contract Compliance Sanction Alternative
R9-30-409. Contract or Protests; Appeals

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Section
R9-30-501. Reserved
R9-30-502. Availability and Accessibility of Services
R9-30-503. Reserved
R9-30-504. Marketing
R9-30-505. Reserved
R9-30-506. Reserved
R9-30-507. Member Record
R9-30-508. Reserved
R9-30-509. Transition and Coordination of Member Care
R9-30-510. Transfer of a Member
R9-30-511. Fraud and Abuse
R9-30-512. Release of Safeguarded Information by the PSA and a Contractor
R9-30-513. Discrimination Prohibition
R9-30-514. Equal Opportunity
R9-30-515. Reserved
R9-30-516. Reserved
R9-30-517. Reserved
R9-30-518. Information to an Enrolled Member
R9-30-519. Reserved
R9-30-520. Financial Statements, Periodic Reports and Information
R9-30-521. Program Compliance Audits
R9-30-522. Quality Management/Utilization Management (QM/UM) Requirements
R9-30-523. Financial Resources
R9-30-524. Continuity of Care

ARTICLE 6. GRIEVANCE AND APPEALS

Section
R9-30-601. General Provisions for all Grievances and Appeals
R9-30-602. Eligibility Appeals and Hearing Requests for an Applicant and a Premium Share Member
R9-30-603. Grievances

ARTICLE 7. PAYMENT RESPONSIBILITIES

Section
R9-30-701. A Premium Share Member's Payment Responsibilities

R9-30-702. The PSA's Scope of Liability: The PSA's Payment Responsibility to Contractors
R9-30-703. Contractor's and Provider's Claims and Payment Responsibilities

ARTICLE 8. MEMBERS' RIGHTS AND RESPONSIBILITIES

Article 8, consisting of Sections R9-30-801 through R9-30-809, adopted effective September 9, 1998 (Supp. 98-3).

Section
R9-30-801. General Intent and Definitions
R9-30-802. Denial of a Request for a Service
R9-30-803. Reduction, Suspension, or Termination of a Service
R9-30-804. Content of Notice
R9-30-805. Exceptions from an Advance of Notice
R9-30-806. Notice in a Case of Probable Fraud
R9-30-807. Expedited Hearing Process
R9-30-808. Maintenance of Records
R9-30-809. Member Handbook

Editor's Note: Article 1, consisting of Sections R9-30-101 through R9-30-107, was adopted and amended under an exemption from certain provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Chapter 186, § 7. Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register and the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval. The Department was required to hold at least two public hearings on these Sections under Laws 1997, Chapter 186, § 7.

ARTICLE 1. DEFINITIONS

R9-30-101. Location of Definitions

A. Location of definitions. Definitions applicable to Chapter 30 are found in the following:

	Definition	Section or Citation
1.	"AHCCCS"	R9-22-101
2.	"Ambulance"	R9-22-102
3.	"Applicant"	R9-30-101
4.	"Chronic disease"	R9-30-102
5.	"Chronically ill" member"	R9-30-102
6.	"Clean claim"	A.R.S. § 36-2904
7.	"Contractor"	R9-22-101
8.	"Copayment"	R9-30-107
9.	"Covered services"	R9-30-102
10.	"Date of application"	R9-30-103
11.	"Day"	R9-22-101
12.	"Eligible for AHCCCS benefits"	R9-30-103
13.	"Emergency medical services"	R9-22-102
14.	"Enrollment"	R9-30-103
15.	"E.P.S.D.T. services"	R9-22-102
16.	"FPL"	R9-30-103
17.	"Fund"	A.R.S. § 36-2923
18.	"Grievance"	R9-30-106
19.	"Head-of-household"	R9-30-103
20.	"Hospital"	R9-22-101
21.	"Household income"	R9-30-103
22.	"Household unit"	R9-30-103
23.	"Inpatient hospital services"	R9-30-101
24.	"Life threatening"	R9-27-102
25.	"Medical record"	R9-22-101
26.	"Medical services"	R9-22-101
27.	"Medically necessary"	R9-22-101
28.	"Month of application"	R9-30-103
29.	"Noncontracting provider"	A.R.S. § 36-2931
30.	"Offeror"	R9-22-106
31.	"Other health care practitioner"	R9-27-101
32.	"Outpatient hospital services"	R9-22-107
33.	"Pharmaceutical services"	R9-22-102
34.	"Plan"	Laws 1997, Ch.186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21
35.	"Population"	Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21
36.	"Practitioner"	R9-22-102
37.	"Premium"	R9-30-107
38.	"Premium Share"	R9-30-107
39.	"Premium Share member"	R9-30-103
40.	"Pre-payment"	R9-30-107
41.	"Prescription"	R9-22-102
42.	"Primary care provider"	R9-22-102
43.	"Prior authorization"	R9-22-102
44.	"Providers"	A.R.S. § 36-2901
45.	"PSA"	R9-30-101
46.	"PSDP"	R9-30-101
47.	"Quality management"	R9-22-105
48.	"Redetermination"	R9-30-103
49.	"Referral"	R9-22-101
50.	"RFP"	R9-22-105
51.	"Service area"	R9-30-103
52.	"Scope of services"	R9-22-101
53.	"Subcontract"	R9-22-101
54.	"System"	A.R.S. § 36-2901
55.	"Utilization management"	R9-22-105

B. General definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.

1. "Applicant" means a person who submits, or on whose behalf is submitted, a signed and dated application for enrollment in the PSDP.
2. "Inpatient hospital services" means medically necessary services that require an inpatient stay in an acute hospital. Inpatient hospital services are provided by or under the direction of a physician or other health care practitioner upon referral from a Premium Share member's primary care provider.
3. "PSA" means the Premium Sharing Administration, which is the entity designated by the AHCCCS Director to carry out the administrative functions of the PSDP under Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.
4. "PSDP" means Premium Sharing Demonstration Project, which is a 3-year pilot program established under A.R.S. § 36-2923.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-102. Scope of Services Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.

1. "Chronic disease" means a non-acute condition that is not caused by alcohol, drug, or chemical addiction, and if not treated has a reasonable medical probability of causing a life-threatening situation or death. For the purposes of the PSDP, chronic disease includes only the following diagnoses as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21:
   a. Alpha-1-Antitrypsin Deficiency,
   b. Amytrophic lateral sclerosis (Lou Gehrig's Disease),
   c. Cardiomyopathy,
   d. Chronic liver disease,
   e. Chronic pancreatitis,
   f. Chronic rheumatoid arthritis,
   g. Congenital heart disease,
   h. Cystic fibrosis,
   i. Growth hormone deficiency,
   j. Hematologic cancer patients,
   k. Hemophilia,
   l. History of any solid organ transplant,
   m. HIV/AIDS,
   n. Hodgkin's disease,
   o. Metastatic cancer,
   p. Multiple sclerosis,
   q. Muscular dystrophy,
   r. Pulmonary hypertension, and
   s. Sickle cell disease.
2. "Chronically ill member" means a person enrolled with PSDP, who has been diagnosed with a chronic disease as defined in subsection (1) and who has an annual gross household income at or below 400% of the FPL as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.
3. "Covered services" means the health and medical services specified in Article 2 of this Chapter.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-103. Eligibility and Enrollment Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.

1. "Date of application" means the date a signed and dated PSDP application is received in the PSA office.
2. "Eligible for AHCCCS benefits" means enrolled as a member of the Arizona Health Care Cost Containment System, beginning the 1st day of the month following the date a person has been determined eligible under A.R.S. 36-2901(4)(a),(b),(c), and (h).
3. "Enrollment" means the process by which a person applies for coverage, is determined eligible, selects a PSDP contractor, and begins making premium payments to the PSA.
4. "FPL" means the federal poverty level, the federal poverty guidelines published annually by the United States Department of Health and Human Services.
5. "Head-of-household" means the household member who assumes the responsibility for providing PSDP eligibility information for the household unit in accordance with Article 3 of this Chapter. The head-of-household may designate a nonhousehold member as the household's representative.
6. "Household income" means the total gross amount of all money received by all eligible or ineligible household members such as cash, a check, a cashier's check, a money order, or as a deposit into the household member's solely or jointly owned financial account.
7. "Household unit" means 1 or more persons who reside together in a household and are considered in determining eligibility.
8. "Month of application" means the calendar month during which a signed and dated PSDP application is postmarked if mailed or, if hand-delivered, the date of actual delivery.
9. "Premium Share member" means an enrollee as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.
10. "Redetermination" means the periodic submission of a PSDP redetermination form by a current Premium Share member requesting continuation of PSDP coverage, and the review of that application and determination of ongoing eligibility and premium by the PSA.
11. "Service area" means the area for which a contractor has contracted with AHCCCS to provide services to Premium Share members.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-104. Reserved

R9-30-105. Reserved

R9-30-106. Grievance and Appeals Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning: "Grievance" means a complaint initiated in accordance with Article 6 of this Chapter.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-107. Payment Responsibilities Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.

1. "Copayment" means a monetary amount a Premium Share member pays directly to a provider at the time covered service is rendered.
2. "Premium" means the total amount due monthly for the provision of covered services to Premium Share members.
3. "Premium share" means the portion of the premium, not to exceed 4% of the Premium Share member's gross annual household income, a Premium Share member whose household income is equal to or less than 200% of

FPL must pay monthly for the provision of covered services.

4. "Pre-payment" means submission of the Premium Share household's share of the premium. The prepayment is due 30 days before the effective date of coverage.

Historical Note

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Editor's Note: Article 2, consisting of Sections R9-30-201 through R9-30-217, was adopted and amended under an exemption from certain provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Chapter 186, § 7. Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register and the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval. The Department was required to hold at least two public hearings on these Sections under Laws 1997, Chapter 186, § 7.

ARTICLE 2. SCOPE OF SERVICES

R9-30-201. General Requirements

A. In addition to the requirements and limitations specified in this Chapter, the following general requirements apply:

1. Covered services provided to a Premium Share member shall be medically necessary and provided by or under the direction of a primary care provider or dentist; specialist services shall be provided under referral from and in consultation with the primary care provider.
   a. The role or responsibility of a primary care provider, as defined in these rules, shall not be diminished by the primary care provider delegating the provision of primary care for a Premium Share member to a practitioner.
   b. Behavioral health screening and evaluation services may be provided without referral from a primary care provider. Behavioral health treatment services shall be provided only under referral from, and in consultation with, the primary care provider, or upon authorization by the contractor or its designee.
   c. The contractor may waive the referral requirements.
2. Behavioral health services are limited to 30 days of inpatient care and 30 outpatient visits per contract year as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.
3. Services shall be rendered in accordance with state laws and regulations, the *Arizona Administrative Code*, and PSA contractual requirements.
4. Experimental services as determined by the Director or services provided primarily for the purpose of research shall not be covered.
5. PSDP services shall be limited to those services that are not covered for a Premium Share member who is covered by another funding source as specified in R9-30-301.
6. Services or items, if furnished gratuitously, are not covered and payment shall be denied.
7. Personal care items are not covered and payment shall be denied.
8. Medical or behavioral health services shall not be covered if provided to:
   a. An inmate of a prison;
   b. A person who is in residence at an institution for the treatment of tuberculosis; or
   c. A person who is in an institution for the treatment of a mental disorder, unless provided under this Article.

B. The PSA may require that providers be AHCCCS registered. Services may be provided by AHCCCS registered personnel or facilities that meet state requirements and are appropriately licensed or certified to provide the services.

C. Payment for services or items requiring prior authorization may be denied if prior authorization is not obtained from the contractor. Emergency services as defined in A.A.C. R9-22-102(7) do not require prior authorization; however, the Premium Share member must notify the contractor as required in R9-30-210(C).

1. The contractor shall prior authorize services for a Premium Share member based on the diagnosis, complexity of procedures, and prognosis, and be commensurate with the diagnostic and treatment procedures requested by the Premium Share member's primary care provider or dentist.
2. Services for unrelated conditions requiring additional diagnostic and treatment procedures require additional prior authorization.
3. In addition to the requirements of Article 7 of this Chapter, written documentation of diagnosis and treatment may be required for reimbursement for services that require prior authorization.

D. A covered service rendered to a Premium Share member shall be provided within the service area of the Premium Share member's contractor except when:

1. A primary care provider refers a Premium Share member out of the contractor's area for medical specialty care;
2. A covered service that is medically necessary for a Premium Share member is not available within the contractor's service area;
3. A net savings in service delivery costs can be documented without requiring undue travel time or hardship for a Premium Share member or the Premium Share member's household;
4. A Premium Share member is placed in a nursing facility located out of the contractor's service area with health plan approval;
5. The service is otherwise authorized by the contractor based on medical practice patterns, and cost or scope of service considerations; or
6. The service is an emergency service as defined in R9-30-210.

E. When a Premium Share member is traveling or temporarily outside of the service area of the Premium Share member's contractor, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

F. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in these rules and in contract.

G. The Director shall determine the circumstances under which a Premium Share member may receive services, other than emergency services as specified in subsection (E), from service providers outside the Premium Share member's county of residence or outside the state. Criteria considered by the Director in making this determination shall include availability, accessibility of appropriate care, and cost effectiveness.

H. If a Premium Share member is referred out of the contractor's service area to receive an authorized medically necessary service for an extended period of time, the contractor shall also provide all other medically necessary covered services prior

authorized by the health plan for the Premium Share member during that time.

I. The restrictions, limitations, and exclusions in this Article shall not apply to the costs associated with providing any non-covered service to a Premium Share member and shall not be included in development or negotiation of capitation.

J. Under A.R.S. § 36-2907 the Director may, upon 30 days advance written notice to contractors, modify the list of services for all Premium Share members.

K. A contractor may withhold nonemergency medical services to a Premium Share member who does not pay a copayment in full at time the service is rendered as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.

Historical Note

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R9-30-202. Reserved

R9-30-203. Reserved

R9-30-204. Inpatient General Hospital Services

A. The contractor shall provide inpatient general hospital accommodations and appropriate staffing, supplies, equipment, and services for:

1. Maternity care;
2. Neonatal intensive care (NICU);
3. Intensive care (ICU);
4. Surgery;
5. Nursery;
6. Routine care; and
7. Behavioral health (psychiatric) care:
   a. A Premium Share member is eligible for a maximum of 30 days of impatient behavioral health services per contract year as specified in Laws 1997, Ch.186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.
   b. For the purpose of this Section, the PSDP contract year shall be October 1 through September 30.

B. The contractor shall provide ancillary services as specified by the Director and included in contract:

1. Labor, delivery, recovery rooms, and birthing centers;
2. Surgery and recovery rooms;
3. Laboratory services;
4. Radiological and medical imaging services;
5. Anesthesiology services;
6. Rehabilitation services;
7. Pharmaceutical services and prescribed drugs;
8. Respiratory therapy;
9. Blood and blood derivatives;
10. Central supply items, appliances, and equipment not ordinarily furnished to all patients and which are customarily reimbursed as ancillary services;
11. Maternity services; and
12. Nursery and related services.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-205. Primary Care Provider Services

A. Primary care provider services shall be furnished by a physician or practitioner and shall be covered for a Premium Share member when rendered within the provider's scope of practice under A.R.S. Title 32. Primary care provider services may be provided in an inpatient or outpatient setting and shall include at a minimum:

1. Periodic health examinations and assessments,
2. Evaluations and diagnostic workups,
3. Medically necessary treatment,
4. Prescriptions for medications and medically necessary supplies and equipment,
5. Referrals to specialists or other health care professionals when medically necessary,
6. Patient education,
7. Home visits when determined medically necessary,
8. Covered immunizations, and
9. Covered preventive health services.

B. The following limitations and exclusions apply to primary care provider services:

1. Specialty care and other services provided to a Premium Share member upon referral from a primary care provider shall be limited to the services or conditions for which the referral is made, or for which authorization is given, unless referral is waived by the contractor;
2. If a physical examination is performed with the primary intent to accomplish 1 or more of the objectives listed in subsection (A), it shall be covered by the Premium Share member's contractor, except if there is an additional or alternative objective to satisfy the demands of an outside public or private agency. Alternative objectives may include physical examinations and resulting documentation for:
   a. Qualification for insurance;
   b. Pre-employment physical evaluation;
   c. Qualification for sports or physical exercise activities;
   d. Pilot's examination (FAA);
   e. Disability certification for establishing any kind of periodic payments;
   f. Evaluation for establishing 3rd-party liabilities; or
   g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection (A);
3. Orthognathic surgery shall be covered only for a Premium Share member who is less than 21 years of age; and
4. The following services shall be excluded from PSDP coverage:
   a. Infertility services, reversal of surgically induced infertility (sterilization), and sex change operations;
   b. Abortion counseling services;
   c. Abortions, unless authorized under state law, as specified in A.R.S. § 36-2903.01;
   d. Services or items furnished solely for cosmetic purposes;
   e. Hysterectomies unless determined to be medically necessary;
   f. Elective surgeries with the exception of voluntary sterilization procedures; and
   g. Services or items provided to reconstruct or improve personal appearance after an illness or injury.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1).

Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-206. Organ and Tissue Transplantation Services for a Chronically Ill Member

A. A Premium Share member who has a chronic illness as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, is eligible for the following organ and tissue transplantation services as specified in A.R.S. § 36-2907 if prior authorized and coordinated with the Premium Share member's contractor:

1. Kidney transplantation;
2. Cornea transplantation;
3. Heart transplantation;
4. Liver transplantation;
5. Autologous and allogeneic bone marrow transplantation;
6. Lung transplantation;
7. Heart-lung transplantation;
8. Other organ transplantation if the transplantation is required by A.R.S. § 36-2907, and if other statutory criteria are met; and
9. Immunosuppressant medications, chemotherapy, and other related services including medically necessary dental services required prior to and associated with a transplant.

B. Artificial or mechanical hearts and xenografts are not covered services for organ and tissue transplantation services.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-207. Dental Services

A. Emergency dental care, which encompasses the following services, shall be covered:

1. Emergency oral diagnostic examination including laboratory and radiographs when necessary to determine an emergent condition;
2. Immediate palliative treatment, including extractions when professionally indicated, for relief of severe pain associated with an oral or maxillofacial condition;
3. Initial treatment for acute infection;
4. Immediate and palliative procedures for acute craniomandibular problems and for traumatic injuries to teeth, bone, or soft tissue;
5. Preoperative procedures; and
6. Anesthesia appropriate for optimal patient management.

B. Covered denture services include medically necessary dental services and procedures associated with, and including, the provision of dentures.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1).

R9-30-208. Laboratory, Radiology, and Medical Imaging Services

Laboratory, radiology, and medical imaging services shall be covered services if:

1. Prescribed for a Premium Share member by the primary care provider or the dentist, unless referral is waived by the contractor;
2. Provided in a hospital, clinic, physician office or other health care facility by a licensed health care provider; and
3. Provided by a provider that meets all applicable state license and certification requirements and provides only services that are within the scope of practice stated in the provider's license or certification.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1).

R9-30-209. Pharmaceutical Services

A. Pharmaceutical services may be provided by an inpatient or outpatient provider including hospitals, clinics, or appropriately licensed health care facilities and pharmacies.

B. The contractor shall make pharmaceutical services available during customary business hours and shall be located within reasonable travel distance of a Premium Share member's residence.

C. Pharmaceutical services shall be covered upon authorization by the contractor or its designee's formulary if prescribed for a Premium Share member by:

1. The Premium Share member's primary care provider or dentist;
2. A specialist, upon referral from the premium Share member's primary care provider or dentist; or
3. A specialist without a referral by the Premium Share member's primary care provider or dentist if the contractor has waived the referral requirement.

D. The following limitations shall apply to pharmaceutical services:

1. A medication personally dispensed by a primary care provider or dentist is not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
2. A prescription in excess of a 30-day supply or a 100-unit dose is not covered unless:
   a. The medication is prescribed for a chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is more.
   b. The Premium Share member will be out of the contractor's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 days or 100-unit dose, whichever is more.
3. A nonprescription medication is not covered unless the nonprescription medication is an appropriate alternative medication and less costly than a prescription medication.
4. A prescription is not covered if filled or refilled in excess of the number specified, or if an initial prescription or refill is dispensed after 1 year from the original prescribed order.
5. Approval by the authorized prescriber is required for all changes in or additions to an original prescription. The date of a prescription change is to be clearly indicated and initialed by the dispensing pharmacist.

E. A contractor shall monitor and take necessary actions to ensure that a Premium Share member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being, is provided sufficient services to eliminate any gap in the required pharmaceutical regimen.

Historical Note

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R9-30-210. Emergency Medical Services and Emergency Behavioral Health Services

A. Emergency medical services and emergency behavioral health services shall be provided to a Premium Share member by licensed providers.

B. Emergency medical services and emergency behavioral health services shall be available 24 hours per day, 7 days per week in each contractor's service area.

C. The Premium Share member shall notify the contractor within 48 hours after the initiation of treatment. If a Premium Share member is incapacitated, the provider is responsible for notifying the contractor within 48 hours after the initiation of treatment. Failure of the Premium Share member or provider to notify the contractor as required may result in denial of payment.

D. Consultation provided by a psychiatrist or psychologist shall be covered as an emergency service if required to evaluate or stabilize an acute episode of mental illness or substance abuse.

E. Emergency services do not require prior authorization.

1. Providers, nonproviders, and noncontracting providers furnishing emergency services to a Premium Share member shall notify the Premium Share member's contractor within 12 hours of the time the Premium Share member presents for services;
2. If a Premium Share member's medical condition is determined not to be an emergency medical condition as defined in A.A.C. R9-22-101, the provider shall notify the Premium Share member's contractor before initiation of treatment and follow the prior authorization requirements and protocol of the contractor regarding treatment of the Premium Share member's nonemergency condition. Failure by the provider to provide timely notice or to comply with prior authorization requirements of the contractor constitutes cause for denial of payment.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-211. Transportation Services

A. Emergency ambulance services.

1. Emergency ambulance transportation shall be a covered service for a Premium Share member. Payment shall be limited to the cost of transporting the Premium Share member in a ground or air ambulance:
   a. To the nearest appropriate provider or medical facility capable of meeting the Premium Share member's medical needs; and
   b. When no other means of transportation is both appropriate and available.
2. A ground or air ambulance transport that originates in response to a 911 call or other emergency response system shall be reimbursed according to the terms and conditions that the PSA specified in the contractor's contract, if the medical condition at the time of transport justified a medically necessary or emergency ambulance transport. No prior authorization is required for reimbursement of these transports.
3. Determination of whether transport is medically necessary shall be based upon the medical condition of the Premium Share member at the time of transport.
4. A ground or air ambulance provider furnishing transportation in response to a 911 call or other emergency response system shall notify the Premium Share member's contractor within 10 working days from the date of transport. Failure to notify the contractor may constitute cause for denial of claims.

B. Medically necessary nonemergency transportation. A Premium Share member is responsible for the full cost of any nonemergency transportation as specified in Laws 1997, Ch.186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, except as specified in subsection (A).

Historical Note

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R9-30-212. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices

A. Medical supplies, durable equipment, and orthotic and prosthetic devices shall be covered services if:

1. Prescribed for a Premium Share member by the Premium Share member's primary care provider, unless referral is waived by the contractor; or
2. Provided in compliance with requirements of this Chapter; and
3. Provided in compliance with the contractor's requirements.

B. Medical supplies include consumable items covered under Medicare that are provided to a Premium Share member and that are not reusable.

C. Medical equipment includes any durable item, appliance, or piece of equipment that is designed for a medical purpose, is generally reusable by others, and is purchased or rented for a Premium Share member.

D. Prosthetic and orthotic devices include only those items that are essential for the habilitation or rehabilitation of a Premium Share member.

E. Prescriptive lenses are covered if they are the sole prosthetic device after a cataract extraction.

F. The following limitations apply:

1. If medical equipment can not be reasonably obtained from alternative resources at no cost, the medical equipment shall be furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the equipment shall not exceed the cost of the equipment if purchased.
2. Reasonable repair or adjustment of purchased medical equipment shall be covered if necessary to make the equipment serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.
3. Changes in, or additions to, an original order for medical equipment shall be approved by the Premium Share member's primary care provider or authorized prescriber and shall be indicated clearly and initialed by the vendor. No change or addition to the original order for medical equipment may be made after a claim for services has been submitted to the Premium Share member's contractor, without prior written notification of the change or addition.
4. Rental fees shall terminate:
   a. No later than the end of the month in which the primary care provider or authorized prescriber certifies that the Premium Share member no longer needs the medical equipment;
   b. When the Premium Share member is no longer eligible for PSDP services; or

c. When the Premium Share member is no longer enrolled with a contractor, with the exception of transition of care as specified by the Director.

5. Personal incidentals, including items for personal cleanliness, body hygiene, and grooming, shall not be covered unless needed to treat a medical condition and provided in accordance with a prescription.
6. First aid supplies shall not be covered unless they are provided in accordance with a prescription.
7. Hearing aids and prescriptive lenses shall not be covered for a Premium Share member who is 21 years of age and older, unless authorized under subsection (E).

G. Liability and ownership.

1. Purchased durable medical equipment provided by a contractor for a Premium Share member, but which is no longer needed, may be disposed of in accordance with each contractor's policy.
2. The contractor shall retain title to purchased durable medical equipment supplied to a Premium Share member who becomes ineligible or no longer requires its use.
3. If customized durable medical equipment is purchased by the contractor for a Premium Share member, the equipment will remain with the person during times of transition or if the person becomes ineligible.
   a. For purposes of this Section, customized durable medical equipment refers to equipment that has been altered or built to specifications unique to a Premium Share member's medical needs and which, most likely, cannot be used or reused to meet the needs of another person.
   b. Customized equipment obtained fraudulently by a Premium Share member shall be returned for disposal to the Premium Share member's contractor if the customized equipment was purchased for a Premium Share member.

Historical Note

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R9-30-213. Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)

A. The following EPSDT services shall be covered for a Premium Share member less than 21 years of age:

1. Screening services, including:
   a. Comprehensive health and developmental history;
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations according to age and health history;
   d. Laboratory tests; and
   e. Health education, including anticipatory guidance;
2. Vision services, including:
   a. Diagnosis and treatment for defects in vision;
   b. Eye examinations for the provision of prescriptive lenses; and
   c. Provision of prescriptive lenses;
3. Hearing services, including:
   a. Diagnosis and treatment for defects in hearing;
   b. Testing to determine hearing impairment; and
   c. Provision of hearing aids;
4. Dental services including:
   a. Emergency dental services as specified in R9-30-207;
   b. Preventive services including screening, diagnosis, and treatment of dental disease; and
   c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
5. Orthognathic surgery; and
6. Behavioral health services specified in this Chapter;

B. All providers of EPSDT services shall meet the following standards:

1. Provide services by, or under the direction of, the Premium Share member's primary care provider or dentist;
2. Perform tests and examinations in accordance with the PSA Periodicity Schedule:
   a. Refer a Premium Share member as necessary for dental diagnosis and treatment, and necessary specialty care; or
   b. Refer a Premium Share member as necessary for behavioral health evaluation and treatment services.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1).

R9-30-214. Reserved

R9-30-215. Other Medical Professional Services

A. The following medical professional services provided to a Premium Share member by a contractor, shall be covered services when provided in an inpatient, outpatient, or office setting within the limitations specified below:

1. Dialysis;
2. Family planning services, including medications, supplies, devices, and surgical procedures provided to delay or prevent pregnancy. Family planning services are limited to:
   a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV/AIDS blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
   b. Sterilization; and
   c. Natural family planning education or referral;
3. Certified nurse midwife services provided by a certified nurse practitioner in midwifery;
4. Licensed midwife services for prenatal care and home births in low-risk pregnancies if the contractor chooses to provide such services;
5. Podiatry services when ordered by a Premium Share member's primary care provider;
6. Respiratory therapy;
7. Ambulatory and outpatient surgery facilities services;
8. Home health services under A.R.S. § 36-2907(D);
9. Private or special duty nursing services when medically necessary and prior authorized;
10. Rehabilitation services including physical therapy, occupational therapy, audiology and speech therapy within limitations in this Article;
11. Total parenteral nutrition services;
12. Chemotherapy; and
13. A Premium Share member is eligible for a maximum 30 days of inpatient and of 30 outpatient behavioral health visits per contract year as specified in Laws 1997, Ch 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.

B. The following shall be excluded as PSDP covered services:

1. Occupational and speech therapies provided on an outpatient basis for a Premium Share member who is 21 years of age or older;

2. Physical therapy provided only as a maintenance regimen;
3. Abortion counseling; or
4. Services or items furnished solely for cosmetic purposes.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-216. Nursing Facility Services

A. Nursing facility services including room and board shall be covered for a maximum of 90 days per contract year if the medical condition of a Premium Share member would require hospitalization if nursing facility services were not provided.

B. Except as otherwise provided in 9 A.A.C. 28, the following services shall be excluded for purpose of separate billing if provided in a nursing facility:
1. Nursing services including but not limited to:
   a. Administration of medication;
   b. Tube feedings;
   c. Personal care services (assistance with bathing and grooming);
   d. Routine testing of vital signs; and
   e. Maintenance of catheters;
2. Basic patient care equipment and sickroom supplies, including, but not limited to:
   a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over-the-counter remedies;
   b. Bathing and grooming supplies;
   c. Identification devices;
   d. Skin lotions;
   e. Medication cups;
   f. Alcohol wipes, cotton balls, and cotton rolls;
   g. Rubber gloves (non sterile);
   h. Laxatives;
   i. Beds and accessories;
   j. Thermometers;
   k. Ice bags;
   l. Rubber sheeting;
   m. Passive restraints;
   n. Glycerin swabs;
   o. Facial tissue;
   p. Enemas;
   q. Heating pads;
   r. Diapers; and
   s. Alcoholic beverages;
3. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating;
4. Any services that are included in a nursing facility's room and board charge or services that are required of the nursing facility to meet federal mandates, state licensure standards, or county certification requirements;
5. Administrative physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
6. Physical therapy prescribed only as a maintenance regimen; and
7. Assistive devices and durable medical equipment.

C. Each admission shall be prior authorized by the contractor for a Premium Share member.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-217. Behavioral Health Services

A. General requirements. A Premium Share member with a behavioral or substance abuse disorder shall be eligible for behavioral health services with the limitations of 30 days of inpatient and 30 outpatient visits per contract year as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.

B. Service delivery system and referral. A contractor shall be responsible for the provision of medically necessary behavioral health services to a Premium Share member.

C. Covered behavioral health services for a Premium Share member:
1. The following requirements apply with respect to behavioral health services provided under this Article, subject to all applicable exclusions and limitations.
   a. The service shall be medically necessary, cost effective, and PSDP reimbursable;
   b. The service shall be provided by qualified service providers as specified in contract;
   c. A service provider, as applicable, shall contract with a contractor;
   d. A service shall be authorized, as applicable, by the contractor; and
   e. A service shall be provided in appropriate residential settings which meet state licensing standards;
2. The following behavioral health services shall be covered, subject to the limitations and exclusions in the contract:
   a. Inpatient services,
   b. Professional services,
   c. Rehabilitation services,
   d. Evaluation and case management services,
   e. Behavioral health-related services,
   f. Emergency transportation services,
   g. Qualifications and standards of participation for service providers, and
   h. Utilization control.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

Editor's Note: Article 3, consisting of Sections R9-30-301 through R9-30-306, was adopted, amended, and repealed under an exemption from certain provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Chapter 186, § 7. Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register and the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval. The Department was required to hold at least two public hearings on these new Sections under Laws 1997, Chapter 186, § 7.

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-30-301. General Requirements

A. Expenditure limit. Enrollment in the PSDP is limited to funding as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21 and Laws 1997, Ch. 186, § 4, as amended by Laws

1997, 2nd Special Session, Ch. 1, § 2. The PSA will accept members subject to the availability of funds. A person determined eligible shall be placed on a waiting list after it is estimated that 80% of the annual expenditures will be reached. When funding becomes available, persons on the waiting list will be contacted and asked to update the original application if it is more than 60 days old. Spaces will be filled in the order that the applicants are determined eligible.

B. Participation. Subject to the expenditure limitation specified in subsection (A) and the cap and waiting list requirements in subsection (D), a person who meets all eligibility requirements shall be approved and shall pay:
1. A copayment every time a service is received, and
2. A monthly income-based premium.

C. Health history questionnaire. An applicant who has been determined eligible for the PSDP shall receive a health history questionnaire which must be completed by each eligible household member and returned with the 1st premium payment for each household member to be enrolled in the PSDP.

D. Chronically ill cap and waiting list.
1. The PSA shall limit the total number of all chronically ill members in the PSDP to 200 persons as specified in Laws 1997, Ch. 186, § 4, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 2. When the PSDP has reached this limitation, and subject to the expenditure limit as specified in subsection (A), persons determined eligible shall be placed on a waiting list. When funding becomes available, persons on the waiting list will be contacted, and asked to update the original application if it is more than 60 days old. Spaces will be filled in the order that the applicants are determined eligible.
2. The chronic illness cap applies to all chronically ill persons whose gross household income does not exceed 400% of FPL.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-302. Time-frames for Determining Eligibility

A. Within 20 days following receipt of application, the PSA shall review the application and contact the applicant if additional information and verification is needed to complete the eligibility determination.

B. Provisions of verification:
1. Applicants shall provide the PSA with information and corresponding verification requested in subsection (A) within 10 days following the date the information and verification was 1st requested by the PSA.
2. The PSA shall extend the time period by 10 days if before the expiration of the time period allotted in subsection (B)(1) the head-of-household requests additional time.

C. The PSA shall determine eligibility within 20 days from the date all information necessary to determine eligibility is received by PSA.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Section repealed, new Section adopted by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-303. Conditions of Eligibility

A. General eligibility requirements for the chronically ill member and the nonchronically ill member.
1. Citizenship/alien status. An applicant shall meet 1 of the following citizenship requirements:
   a. Be a United States citizen as specified in A.R.S § 36-2903.01 and Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21; or
   b. Be a qualified alien as specified in A.R.S. § 36-2903.01.
2. Residency. An applicant shall be a resident of Arizona as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, and a primary resident of 1 of the following:
   a. Cochise County;
   b. Maricopa County;
   c. Pima County; or
   d. Pinal County.
3. Income.
   a. The PSA shall determine the gross household income from documentation submitted by the applicant that identifies income received by all household members during the 3 full calendar months immediately prior to the month of application.
   b. The PSA shall count gross income from employment, self-employment, rental, public assistance benefits, other earned and unearned income.
   c. The following amounts shall be deducted from the gross household income:
      i. Payments paid to cover the costs of doing business, and
      ii. Payments paid to cover the costs of producing income from rental property as specified in the PSDP policy manual, and
      iii. Repayment of advances or overpayments by the same payer when those repayments are deducted directly from the income being considered.
   d. The following in-kind income shall be disregarded:
      i. Food stamps,
      ii. Earned income tax credits, and
      iii. Certain lump sum payments.
4. Income limits. The annualized gross household income, less deductions shall not exceed 200% of the FPL as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21 for a nonchronically ill member and 400% FPL for a chronically ill person.
5. Income verification.
   a. The applicant shall provide verification for all sources of income received by all household members from all sources during the 3 full calendar months prior to the month of application.
   b. If the applicant fails to provide verification of income, the application shall be denied.
6. Household composition. The PSA determines eligibility by household unit. All members of the household must be included on the application. The following persons, when living together, are members of the same household:
   a. Head-of-household;
   b. A legal spouse of the head-of-household. This includes spouses who are temporarily away from the home due to employment or who are seeking employment.

c. A common-law spouse of the head-of-household. A common-law spouse is a legal spouse when the applicant and spouse have lived together in, and met the requirements for, common-law marriage in a state that recognizes these marriages;
d. Other parent. The other parent or guardian of a common dependent child when that person is not the spouse of the head-of-household; and
e. A dependent child. A dependent child who is unmarried, has not reached age 19, and is a biological child, adopted child, a step-child of the head-of-household or spouse or both, or the biological child of another dependent child who is a household member, or a child for whom the head-of-household or spouse is a legal guardian unless that child's adult parent is sharing the residence.

7. Cooperation. An applicant shall cooperate in providing the necessary information to verify eligibility.
8. Fraud. An applicant who has been convicted of fraud or abuse in the following programs in any state is not eligible to participate in the Premium Sharing Demonstration Program:
   a. Temporary Assistance to Needy Families (TANF);
   b. Aid to Families with Dependent Children (AFDC);
   c. General Assistance (GA);
   d. KidsCare;
   e. Food Stamps;
   f. Programs established under Title XIX of the Social Security Act; or
   g. State or county sponsored medical assistance programs.
9. Other health care coverage. Except as provided in subsection (B), an applicant who is currently insured, or who has had health care coverage other than AHCCCS in the 6 months prior to application for the PSDP, is not eligible for coverage under the PSDP, as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.
10. Other limitations.
    a. Veterans Administration (VA) coverage. An applicant who has VA coverage for a medical condition is not eligible for coverage of only that medical condition or medical conditions under the PSDP.
    b. Medicare benefits. An applicant who has Medicare Part A, Medicare Part B, or both, is not eligible for coverage under the PSDP.
    c. AHCCCS benefits. An applicant who is eligible for AHCCCS medical benefits or KidsCare under A.R.S. Title 11, Chapter 2, or A.R.S. Title 36, Chapter 29, is not eligible for the PSDP. The PSA may screen an application to determine if an applicant is eligible for any of these programs. An applicant shall declare whether the applicant has been determined ineligible for these programs. An applicant is encouraged to apply for AHCCCS benefits or KidsCare prior to approval for the PSDP.
    d. Exceptions to AHCCCS benefits. Women who are eligible for family planning assistance under the Sixth Omnibus Budget Reconciliation Act (SOBRA) may apply for the PSDP as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.
    e. Payor of last resort. The PSA contractor shall not be the primary payor for any claim involving worker's compensation, automobile insurance, or homeowner's insurance.

B. Requirements for a chronically ill member.
1. Limited enrollment. There is a 200-space limit for the chronically ill. An applicant shall be placed on a waiting list once the spaces are filled or expenditure limits are reached as specified in subsection (A)(1) and Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21 and Laws 1997, Ch. 186, § 4, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 2.
2. Other health care coverage. The requirements in subsection (A)(9) do not apply to a chronically ill member who has an annual gross household income equal to or greater than 200% but equal to or less than 400% of FPL.
3. Chronic illness coverage. The following limitations shall apply for any applicant who meets the requirements for coverage as a chronically ill member as specified in R9-30-102.
   a. Continuous AHCCCS coverage. As a condition of eligibility, an applicant with an annual gross household income equal to or greater than 200% of FPL and equal to less than 400% of FPL must have been eligible for health care services under A.R.S. § 11-297 for at least 12 consecutive months out of the prior 15 consecutive months immediately preceding the month of application for the PSDP.
   b. Medical verification. A member who is chronically ill shall submit a written statement from a physician indicating that the member's illness meets the definition of chronic disease as specified in R9-30-102.
   c. Premium. A chronically ill member and each household member whose gross household income is equal to or less than 400% of the FPL but greater than 200% of the FPL shall pay the full premium as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.
   d. Failure to claim chronic disease. A chronically ill member who fails to state that the member has 1 of the chronic diseases as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, and R9-30-102 at the time of application may be denied or referred to the PSA for potential fraud.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-304. Enrollment

A Premium Share member shall pay the premiums and copayments as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, for continued enrollment in the PSDP.

1. Health plan choice.
   a. Each eligible household unit shall select a health plan at the time of application.
   b. PSA shall enroll all eligible household members with the same health plan.
   c. Each eligible household unit shall have freedom of choice of a PSDP health plan when there are 1 or more health plans in the service area.

2. Open enrollment. The household unit may change contractors during the annual enrollment choice period.

Historical Note
Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-305. Disenrollment
A Premium Share member shall be disenrolled from the PSDP as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.

1. Reasons for disenrollment. A Premium Share member shall be disenrolled from the PSDP when eligibility criteria, as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, are no longer met:
   a. Nonpayment of premiums and copayments;
   b. Moving out of the participating counties served by the PSDP;
   c. Providing false or fraudulent information on the Premium Sharing application;
   d. Two submissions of a check returned for non-sufficient funds during enrollment;
   e. No longer meeting the eligibility requirements; identified in R9-30-303;
   f. The PSDP expires; or
   g. Failure or refusal to cooperate in the eligibility process or provide requested information.
2. Exception. A Premium Share member who is confined to a hospital on the effective date of disenrollment shall continue to receive coverage until the contractor's Medical Director or designee determines that care in the hospital is no longer medically necessary for the condition for which the member was admitted or the Premium Share member is discharged from the hospital.
3. Grievance and appeal process. A Premium Share member has a right to file a grievance or appeal as specified in R9-30-601 et seq.
4. PSDP participation. A Premium Share member who has been disenrolled from the PSDP shall not be allowed to re-enroll for a period of 12 consecutive months. The 12-month period begins with the date of disenrollment and continues for 12 full calendar months as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.
5. Health Insurance Portability and Accountability Act (HIPAA) of 1996. A Premium Share member who has been disenrolled shall be allowed to use enrollment in the PSDP as creditable coverage as defined in P.L. 104-191 as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.

Historical Note
Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-306. Redetermination
A. The PSA shall conduct a redetermination of eligibility on each Premium Sharing household unit once every 6 months as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, unless the household unit becomes ineligible prior to this time.
B. The 6-month period shall begin with the month the household unit is enrolled.
C. The PSA shall conduct a redetermination on a Premium Share household unit when a Premium Share member moves from 1 PSDP county to another participating PSDP county.
D. A Premium Share member shall remain enrolled in the PSDP if the member continues to meet the criteria in this Article. The Premium Share member shall have a redetermination completed 6 months from the new date of eligibility.

Historical Note
Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

Editor's Note: Article 4, consisting of Sections R9-30-401 through R9-30-409, was adopted and amended under an exemption from certain provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Chapter 186, § 7. Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register and the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval. The Department was required to hold at least two public hearings on these Sections under Laws 1997, Chapter 186, § 7.

ARTICLE 4. CONTRACTS

R9-30-401. General Provisions
A. Requirements. The PSA and qualified providers of health care who have contracts to provide services under AHCCCS shall conform to the requirements in this Article and Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21. A contractor that has contracts and subcontracts entered into in accordance with this Article shall have records on file.
B. Contract. A contract may be cancelled or rejected in whole or in part, as specified in contract if it is deemed by the Director to be in the best interest of the state. The reasons for cancellation or rejection shall be made part of the contract file.
C. Damages or claims. Offerors as defined in R9-22-106(5) shall have no right to damages or basis for any claims against the state, its employees, or agents, arising out of any action by the PSA under the provisions of subsection (B).

Historical Note
Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-402. Reserved

R9-30-403. PSA's Contracts with Contractors
A. As specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21, the AHCCCS Administration is authorized to contract with AHCCCS' Health Plans under A.R.S. § 36-2912.
B. If the Director determines there is insufficient coverage in a county participating in the PSDP, the Director shall attempt to contract with a prepaid capitated provider as defined in A.R.S. § 36-2901, to provide services under the PSDP, as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.

C. Each contract between the PSA and a contractor shall be in writing and contain at least the following information:
1. The method and amount of compensation or other consideration to be received by the contractor;
2. The name and address of the contractor;
3. The population to be covered by the contract;
4. The amount, duration, and scope of medical services to be provided, or for which compensation will be paid;
5. The term of the contract, including the beginning and ending dates, as well as methods of extension, renegotiation, and termination;
6. A provision that the Director may evaluate, through inspection or other means, the quality, appropriateness, or timeliness of services performed under the contract;
7. A description of member, medical and cost recordkeeping systems, and a provision that the Director may audit and inspect any of the contractor's records that pertain to services performed and determinations of amounts payable under the contract;
8. Records shall be maintained by the contractor for 5 years from the date of final payment or, for records relating to costs and expenses to which the PSA has taken exception, 5 years after the date of final disposition or resolution of the exception;
9. A provision that contractors maintain all forms, records, and statistical information required by the Director for purposes of audit and program management. This material, including files, correspondence, and related information pertaining to services rendered or claims for payments shall be subject to inspection and copying by the PSA during normal business hours at the place of business of the person or organization maintaining the records;
10. A provision that the contractor safeguard information;
11. A provision that the contractor arrange for the collection of any required copayment by the provider;
12. A provision that the contractor will not bill or attempt to collect from a Premium Share member for any covered service except as may be authorized by statute or rules in this Chapter;
13. A provision that the contract will not be assigned or transferred without the prior approval of the Director;
14. Procedures and criteria for terminating the contract;
15. Procedures for terminating enrollment;
16. Procedures for choice of health professionals;
17. A provision that a contractor provide for an internal grievance procedure that:
    a. Is approved in writing by the PSA;
    b. Provides for prompt resolution; and
    c. Ensures the participation of persons with authority to require corrective action;
18. A provision that the contractor maintain an internal quality management system;
19. A provision that the contractor submit marketing plans, procedures, and materials to the PSA for approval before implementation;
20. A statement that all representations made by contractors or authorized representatives are truthful and complete to the best of their knowledge;
21. A provision that the contractor is responsible for all:
    a. Tax obligations;
    b. Workers' Compensation Insurance; and
    c. All other applicable insurance coverage, for itself and its employees, and that the PSA has no responsibility or liability for any of the taxes or insurance coverage; and
22. A provision that the contractor agrees to comply with all applicable statutes, rules, and policies.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-404. Subcontracts

A. Approval. A contractor entering into a subcontract to provide services to a Premium Share member must meet the requirements specified in the contract. A subcontract and any amendment to a subcontract shall be subject to review and approval by the Director.

B. Subcontracts. Each subcontract shall be in writing and include:
1. The subcontract that is to be governed by, and construed in accordance with all laws, rules, policies, and contractual obligations of the contractor;
2. Provision to notify the PSA in the event the subcontract is amended or terminated;
3. Provision that assignment or delegation of the subcontract is voidable, unless prior written approval is obtained from the PSA;
4. Provision to hold harmless the state, the Director, the PSA, and a Premium Share member in the event the contractor can not or will not pay for covered services performed by the subcontractor;
5. Provision that the subcontract and subcontract amendments are subject to review and approval by the Director as established in these rules and that a subcontract or subcontract amendment may be terminated, rescinded, or cancelled by the Director for a violation of these rules;
6. Provision to hold harmless and indemnify the state, the Director, the PSA, or a Premium Share member, through the negligence of the subcontractor;
7. Provision that a Premium Share member is not to be held liable for payment to a subcontractor in the event of contractor's bankruptcy;
8. The method and amount of compensation or other consideration to be received by the subcontractor;
9. The amount, duration, and scope of medical services to be provided by the subcontractor, for which compensation will be paid; and
10. The requirements contained in R9-30-403(C)(1) through (14) and (C)(20) through (22) but substituting the term "subcontractor" wherever the term "contractor" is used.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-405. Contract Records

All contract records shall be retained for a period of 5 years and disposed of as specified in A.R.S. § 41-2550.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1).

R9-30-406. Merger, Reorganization, Change in Ownership, and Contract Amendments

A. Merger, reorganization, or change in ownership. The Director shall prior approve any proposed merger, reorganization, or change in ownership of a contractor.

B. Amendment. The Director shall prior approve any proposed merger, reorganization, or change in ownership of a subcontractor that is related to or affiliated with the contractor and shall require a contract amendment. To be effective, contract amendments shall be in writing and executed by the Director.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-407. Suspension, Modification, or Termination of Contract

A. General. The Director may suspend, deny, refuse or fail to renew, or terminate a contract or subcontract for good cause.

B. Modification and termination of the contract without cause. The AHCCCS Administration and contractor, by mutual consent, may modify or terminate the contract at any time without cause. Additionally, the AHCCCS Administration may terminate or suspend the contract in whole or in part without cause effective 30 days after mailing written notice of termination or suspension by certified mail, return receipt requested, to the contractor.

C. Notification.

1. The Director shall provide the contractor written notice of intent to:
   a. Suspend;
   b. Fail to renew; or
   c. Terminate a contract or related subcontract.
2. The PSA shall provide a notice to a contractor, a Premium Share member, and other interested parties, and shall include:
   a. The effective date; and
   b. Reason for the action.

D. Records. All medical, financial, and other records shall be retained by a terminated contractor in accordance with state laws and rules. Medical records or copies of medical records may be required to be submitted to the Director, or designee, within 10 working days of the effective date of contract termination.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-408. Contract Compliance Sanction Alternative

The Director may impose a sanction upon a contractor that violates any provision of the rules as specified in contract.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-409. Contract or Protest; Appeal

The contractor shall file a grievance as specified in A.A.C. R9-22-804.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1).

Editor's Note: Article 5, consisting of Sections R9-30-501 through R9-30-524, was adopted and amended under an exemption from certain provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Chapter 186, § 7. Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register and the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval. The Department was required to hold at least two public hearings on these Sections under Laws 1997, Chapter 186, § 7.

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-30-501. Reserved

R9-30-502. Availability and Accessibility of Services

A. A contractor shall provide adequate numbers of available and accessible:

1. Institutional facilities;
2. Service locations;
3. Service sites; and
4. Professional, allied, and paramedical personnel for the provision of covered services, including all emergency medical services for 24 hours a day, 7 days a week.

B. A contractor shall minimally provide the following:

1. A ratio of the number of primary care providers to the number of adults and children, as specified in contract;
2. A designated emergency services facility, providing care 24 hours a day, 7 days a week, accessible to a Premium Share member in each contracted service area. One or more physicians and 1 or more nurses shall be on call or on duty at the facility at all times;
3. An emergency services system employing at least 1 physician, registered nurse, physician's assistant, or nurse practitioner, accessible by telephone 24 hours a day, 7 days a week, to a Premium Share member who needs information in an emergency, and to a provider who needs verification of patient membership and treatment authorization;
4. An emergency services call log or database to track the following information:
   a. Premium Share member's name;
   b. Address and telephone number;
   c. Date and time of call;
   d. Nature of complaint or problem; and
   e. Instructions given to a Premium Share member; and
5. A written procedure for communicating emergency services information to a Premium Share member's primary care provider, and other appropriate organizational units.

C. A contractor shall have an affiliation with or subcontract with an organization or person to provide primary care services. The contractor shall agree to provide services under the primary care provider's guidance and direction as specified in contract.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-503. Reserved

R9-30-504. Marketing

The PSA shall require a contractor to develop a marketing plan as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21 and as specified in contract.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-505. Reserved

R9-30-506. Reserved

R9-30-507. Member Record

A contractor shall maintain a Premium Share member service record that contains at least the following for each Premium Share member:

1. Encounter data, if required by PSA;
2. Grievances and appeals;
3. Any informal complaints; and
4. Service information.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-508. Reserved

R9-30-509. Transition and Coordination of Member Care

The PSA shall coordinate and implement disenrollment and reenrollment procedures when a Premium Share member's change of residence requires a change in contractor as specified in contract.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-510. Transfer of a Member

A contractor shall implement procedures to allow a Premium Share member to transfer from the primary care provider of record to another primary care provider within the same contracting organization. Criteria for a transfer include, but are not be limited to:

1. Change in the Premium Share member's health, requiring a different medical focus;
2. Change in the Premium Share member's residence resulting in difficulty in obtaining services from the assigned primary care provider; or
3. Identification of any problem between the Premium Share member and the primary care provider, resulting in deterioration of the primary care provider member relationship.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-511. Fraud and Abuse

A contractor, provider, or noncontracting provider shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse as specified in R9-30-303.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-512. Release of Safeguarded Information by the PSA and a Contractor

A. The PSA, a contractor, a provider, and a noncontracting provider shall safeguard information concerning an applicant, or a Premium Share member, which includes the following:
1. Name and address;
2. Social Security number;
3. Social and economic conditions or circumstances;
4. Agency evaluation of personal information;
5. Medical data and services, including diagnosis and history of disease or disability;
6. State Data Exchange (SDX) tapes from the U.S. Social Security Administration; and
7. Information system tapes from the Arizona Department of Economic Security, if required;

B. The restriction upon disclosure of information does not apply to:
1. Summary data;
2. Statistics;
3. Utilization data; and
4. Other information that does not identify a Premium Share member.

C. The PSA, a contractor, a provider, and a noncontracting provider shall use or disclose information concerning a Premium Share member only under the conditions specified in subsection (D), (E), and (F) and only to:
1. The person concerned;
2. Persons authorized by the person concerned; and
3. Persons or agencies for official purposes.

D. Safeguarded information shall be viewed by or released to only:
1. An applicant;
2. A Premium Share member; or
3. A dependent child, with written permission of a parent, custodial relative, or designated representative, if:
   a. A PSA employee or its authorized representative, or responsible caseworker is present during the examination of the eligibility record; or
   b. As outlined in subsection (E) after written notification to the provider, and at a reasonable time and place.

E. An eligibility case record, medical record, and any other PSDP-related confidential and safeguarded information regarding Premium Share member or applicant, shall be released to persons authorized by the Premium Share member or applicant, only under the following conditions:
1. Authorization for release of information is obtained from the Premium Share member, applicant, or designated representative;
2. Authorization used for release is a written document, separate from any other document, that specifies the following information:
   a. Information or records, in whole or in part, which are authorized for release;
   b. To whom release is authorized;

c. The period of time for which the authorization is valid, if limited; and
d. A dated signature of the adult and mentally competent Premium Share member, applicant, or designated representative. If a Premium Share member, or applicant is a minor, the signature of a parent, custodial relative, or designated representative shall be required unless the minor is sufficiently mature to understand the consequences of granting or denying authorization. If a Premium Share member or applicant is mentally incompetent, authorization shall be under A.R.S. § 36-509; or

3. If an appeal or grievance is filed, the Premium Share member, applicant, or designated representative shall be permitted to review and obtain or copy any nonprivileged record necessary for the proper presentation of the case.

F. Release of safeguarded information to individuals or agencies for official purposes:

1. Official purposes directly related to the administration of the PSDP are:
   a. Establishing eligibility and post-eligibility treatment of income, as applicable;
   b. Providing services for a Premium Share member;
   c. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the PSDP program; and
   d. Performing evaluations and analyses of PSDP operations;
2. For official purposes related to the administration of the PSDP program and only to the extent required in performance of duties, safeguarded information, including case records and medical records, may be disclosed to the following persons without the consent of the applicant, or Premium Share member:
   a. Employees of the PSA;
   b. Employees of the AHCCCS Administration;
   c. Employees of the U.S. Social Security Administration;
   d. Employees of the Arizona Department of Economic Security;
   e. Employees of the Arizona Department of Health Services;
   f. Employees of the U.S. Department of Health and Human Services;
   g. Employees of contractors, program contractors, providers, and subcontractors; and
   h. Employees of the Arizona Attorney General's Office, and the County Attorney, if applicable.
3. Law enforcement officials:
   a. Information may be released to law enforcement officials without the applicant's or Premium Share member's written or verbal consent, for the purpose of an investigation, prosecution, or criminal or civil proceeding relating to the administration of the PSDP program.
   b. The PSA and contractors shall release safeguarded information contained in an applicant's or Premium Share member's medical record to law enforcement officials without the Premium Share member's consent only if the applicant or Premium Share member is suspected of fraud or abuse against the PSDP program.
   c. A contractor shall release the medical record or information in the case record or other information developed in case management or utilization management operations without the Premium Share member's written or verbal consent, for the purpose of an investigation, prosecution, or similar criminal proceeding not in connection with the PSA, only if the law enforcement official requesting the information has statutory authority to obtain the information.
4. The PSA may release safeguarded information including case records and medical records to a review committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant or Premium Share member.
5. Providers shall furnish requested records to the PSA and its contractors at no charge.

G. The holder of a medical record of a former applicant or Premium Share member shall obtain written consent from the former applicant, or Premium Share member before transmitting the medical record to a primary care provider.

H. Subcontractors are not required to obtain written consent from a Premium Share member before transmitting the Premium Share member's medical records to a physician who:

1. Provides a service to the Premium Share member under subcontract with the contractor;
2. Is retained by the subcontractor to provide services that are infrequently used or are of an unusual nature; and
3. Provides a service under the contract.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-513. Discrimination Prohibition

A contractor, provider, and nonprovider shall not discriminate against a Premium Share member as specified in federal and state law.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1).

R9-30-514. Equal Opportunity

A contractor shall meet the requirements in Title VII of the U.S. Civil Rights Act of 1964, 42 U.S.C. 2000(e). A contractor shall, in all solicitations or advertisements for employees placed by, or, on behalf of the contractor:

1. Specify that it is an equal opportunity employer;
2. Send a notice to each labor union representative or worker with a collective bargaining agreement, or other contract or understanding, stating that the contractor is an equal opportunity employer; and
3. Post copies of the notice in conspicuous places available to employees and applicants for employment.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-515. Reserved

R9-30-516. Reserved

R9-30-517. Reserved

R9-30-518. Information to an Enrolled Member

A. Each contractor shall produce and distribute a printed member handbook to each household unit within 10 days of the effective date of coverage. The member handbook shall include the following:
1. A description of all available services and an explanation of any service limitation, and exclusions from coverage or charges for services, when applicable;
2. An explanation of the procedure for obtaining covered services, including a notice stating the contractor shall only be liable for services authorized by a Premium Share member's primary care provider or the contractor;
3. A list of the names, telephone numbers, and business addresses of primary care providers available for selection by the Premium Share member, and a description of the selection process, including a statement that informs the Premium Share member they may request another primary care provider, if they are dissatisfied with their selection;
4. Locations, telephone numbers, and procedures for obtaining emergency health services;
5. Explanation of the procedure for obtaining emergency health services outside the contractor's service area;
6. The causes for which a Premium Share member may lose coverage;
7. A description of the grievance procedures;
8. Copayment schedules;
9. Information on the appropriate use of health services and on the maintenance of personal and family health;
10. Information regarding emergency and medically necessary transportation offered by the contractor; and
11. Other information necessary to use the program.

B. Notification of changes in services. Each contractor shall prepare and distribute to a Premium Share member, a printed member handbook insert describing any changes that the contractor proposes to make in services provided within the contractor's service area. The insert shall be distributed to all household units at least 14 days before a planned change. Notification shall be provided as soon as possible when unforeseen circumstances require an immediate change in services or service locations.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-519. Reserved

R9-30-520. Financial Statements, Periodic Reports and Information

Upon request by the PSA, a contractor shall furnish to the PSA financial statements, periodic reports, and information from its records relating to contract performance as specified in contract.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1).

R9-30-521. Program Compliance Audits

The PSA may conduct a program compliance audit of each contractor on a periodic basis as specified in contract.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1).

R9-30-522. Quality Management/Utilization Management (QM/UM) Requirements

A PSA contractor shall comply with the quality management and utilization review requirements as specified in contract.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1).

R9-30-523. Financial Resources

A. A contractor or offeror shall demonstrate upon request by the PSA that it has:
1. Adequate financial reserves;
2. Administrative abilities; and
3. Soundness of program design to carry out its contractual obligations.

B. As specified in A.R.S. § 36-2912, the Director requires that contract provisions include, but not be limited to:
1. Maintenance of deposits;
2. Performance bonds unless waived as specified in A.R.S. § 36-2912;
3. Financial reserves; or
4. Other financial security, unless waived as specified in A.R.S § 36-2912.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-524. Continuity of Care

A contractor shall establish and maintain a system to ensure continuity of care which shall, at a minimum, include:
1. Referring a Premium Share member who needs specialty health care services;
2. Monitoring a Premium Share member with chronic medical conditions;
3. Providing hospital discharge planning and coordination including post-discharge care; and
4. Monitoring operation of the system through professional review activities.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1).

Editor's Note: Article 6, consisting of Sections R9-30-601 through R9-30-603, was adopted and amended under an exemption from certain provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Chapter 186, § 7. Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register and the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval. The Department was required to hold at least two public hearings on these Sections under Laws 1997, Chapter 186, § 7.

ARTICLE 6. GRIEVANCES AND APPEALS

R9-30-601. General Provisions for all Grievances and Appeals

A. General Requirements. All grievances and appeals regarding Premium Sharing shall be filed and processed in accordance with A.A.C. R9-22-801. All references in that rule to AHCCCS also shall apply to PSA, and all references to health plans and system providers shall also apply to Premium Sharing Plans. In eligibility appeals, PSA is the respondent.

B. The AHCCCS Chief Hearing Officer or designee may deny a request for hearing if the sole issue presented is a state law requiring an automatic change adversely affecting some or all applicants or Premium Share members.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-602. Eligibility Appeals and Hearing Requests for an Applicant and a Premium Share Member

A. Adverse eligibility action. An applicant and a Premium Share member may appeal and request a hearing concerning any of the following adverse eligibility actions:
1. Denial of eligibility;
2. Discontinuance of eligibility;
3. Determination of premium amount; or
4. Chronic illness determination.

B. Notice of an adverse eligibility action. Notice of an adverse eligibility action shall be personally delivered or mailed to the affected person by regular mail. For purposes of this Section, the date of the notice of action shall be the date of personal delivery to the person or the postmark date, if mailed.

C. Appeals and requests for hearing.
1. The applicant or a Premium Share member may appeal and request a hearing regarding any adverse eligibility action by completing and submitting the premium sharing request for hearing form or by submitting a written request containing the following information:
   a. The case name;
   b. The adverse eligibility action being appealed; and
   c. The reason for appeal.
2. The Request for Hearing shall be filed not later than 15 days after the date of the notice of adverse action by mailing or delivering it to the PSA, Office of Legal Assistance. For this Section only, the date of the request for hearing shall be the postmark date, if mailed, or the date of personal delivery.

D. PSA responsibilities.
1. The PSA shall maintain a register which documents the dates on which requests for hearings are submitted.
2. If requested, the PSA shall assist the applicant or a Premium Share member in the completion of the request for hearing form.
3. The pre-hearing summary shall be completed by the PSA and shall summarize the facts and factual basis for the adverse eligibility action.
4. The PSA shall send to the Office of Legal Assistance, the pre-hearing summary, a copy of the case file, documents pertinent to the adverse action, and the request for hearing, which must be received by the Office of Legal Assistance not later than 10 days from the date of the receipt of the request. If the request is submitted directly to the Office of Legal Assistance, the PSA shall send the materials to the Office of Legal Assistance, not later than 10 days from the date of a request for the materials.

E. PSDP coverage during the appeal process.
1. A Premium Share member appealing a discontinuance. A discontinuance is a termination of Premium Sharing benefits. If a Premium Share member requests a timely hearing, the Premium Share member shall receive continued Premium Sharing benefits until an adverse decision on appeal is rendered only if the Premium Share member pays for 3 months worth of premiums, by cashier's check, personal check, or money order, within 15 days of the mailing of the notice of discontinuance.
2. An applicant appealing a denial of Premium Sharing coverage. A denial is an adverse eligibility decision which finds the applicant ineligible for PSDP benefits. In the event that a timely request for hearing is filed, and the denial is overturned, the effective date of PSDP coverage shall be established by the Director in accordance with applicable law.
3. A Premium Share member whose benefits have been continued shall be financially liable for all PSDP benefits received during a period of ineligibility, if a discontinuance decision is upheld by the Director.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-603. Grievances

General Requirements. All grievances regarding PSDP shall be filed and processed in accordance with A.A.C. R9-22-804. All references in that rule to AHCCCS also shall apply to the PSA, and all references to contractors shall also apply to PSDP contractors.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

Editor's Note: Article 7, consisting of Sections R9-30-701 through R9-30-703, was adopted and amended under an exemption from certain provisions of A.R.S. Title 41, Chapter 6, pursuant to Laws 1997, Chapter 186, § 7. Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register and the Department did not submit these rules to the Governor's Regulatory Review Council for review and approval. The Department was required to hold at least two public hearings on these Sections under Laws 1997, Chapter 186, § 7.

ARTICLE 7. PAYMENT RESPONSIBILITIES

R9-30-701. A Premium Share Member's Payment Responsibilities

A. Premium payment requirement. A Premium Share member shall pay the required premium payment established by the PSA as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.

B. Monthly premium payment based on annual household income equal to or less than 200% of FPL, determined by the 3-month income period. A Premium Share member whose gross household income equal to or less than 200% of the FPL

will pay a share of the premium. The Premium Share member will pay the share of the premium depending on the number of eligible persons in the household, and the gross household income.

1. For 1 eligible household member, the premium share will be equal to 2.5% of the gross household income;
2. For 2 eligible household members, the premium share will be equal to 3.0% of the gross household income;
3. For 3 eligible household members, the premium share will be equal to 3.5% of the gross household income;
4. For 4 or more household members, the premium share will be equal to 4% of the gross household income.

C. Premium payment for chronically ill person with gross household income greater than 200% and equal to or less than 400% of FPL. The PSA will require the chronically ill members and their household members whose gross household income is greater than 200% and equal to or less than 400% of the FPL to pay the full premium as established by the PSA.

D. Premium payment schedule. The PSA requires that upon conditional approval of the application, the Premium Share member must pay the premium for the 1st 2 months of coverage. If the PSA receives the premium payment on or before the 15th day of the month, enrollment will begin on the 1st day of the next month. If the PSA receives the premium payment after the 15th day of the month, coverage begins on the 1st day of the 2nd month.

E. When and how to submit premium. The Premium Share member shall submit their monthly premium payment to the PSA at least 30 days in advance of the coverage month.

1. All premiums paid in advance by the Premium Share member are nonrefundable, unless the Premium Share member is disenrolled at least 15 days prior to the month of coverage. Premiums paid during a grievance under R9-30-602(E) will not be reimbursed.
2. A Premium Share member's monthly premium shall be paid with sufficient funds in the form of a:
   a. Cashier's check;
   b. Personal check; or
   c. Money order.

F. Newborns. All newborns shall be enrolled within 31 days of birth to be eligible for coverage. Upon enrollment, the newborn's premium is due to the PSA within 31 days of birth for coverage retroactive to the 1st day of the month in which the birth occurred.

G. Copayment requirements. A Premium Share member shall pay the following copayments as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21:

1. $10 for each physician visit;
2. $25 for each emergency room visit. This fee shall be waived if the person is admitted to the hospital;
3. $50 for each inpatient stay;
4. $50 for each emergency room visit that is for a non-emergency situation;
5. $3 for each prescription that is filled with a generic drug, and 50% of the cost of each prescription that is filled with a brand name pharmaceutical, unless a generic drug is unavailable or not medically appropriate, in which case the Premium Share member shall pay $3 for each prescription;
6. $8 for each laboratory visit not to exceed $8 per site per day or a maximum copayment of $10 per day for a laboratory visit made on the same day in conjunction with a physician visit;
7. $8 for each x-ray service not to exceed $8 per site, per day or a maximum copayment of $10 per day for a x-ray service made on the same day in conjunction with a physician visit;
8. $50 for each behavioral health admission to an inpatient behavioral facility. Premium Share members are eligible for a maximum of 30 days of inpatient behavioral health services annually;
9. $10 for individual outpatient behavioral health services. Premium Share members are eligible for a maximum of 30 outpatient behavioral health visits annually;
10. $5 for outpatient behavioral health group services; and
11. The full cost of any nonemergency transportation.

H. A contractor may withhold nonemergency medical services to a Premium Share member who does not pay copayments in full at the time service is rendered as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-702. The PSA's Scope of Liability: The PSA's Payment Responsibility to Contractors

A. Liability for covered services. The AHCCCS Administration and the PSA shall have no liability for the provision of covered services or for the completion of a plan of treatment to a Premium Share member beyond the date of disenrollment except when the Premium Share member is confined to a hospital as specified in R9-30-305(2). The AHCCCS Administration and the PSA shall be liable until care in the hospital is no longer medically necessary for the condition for which the member was admitted.

B. Subcontracts liability. The AHCCCS Administration and the PSA shall have no liability for subcontracts that a contractor may execute with other parties.

C. Contractor's liability for costs. The contractor shall indemnify and hold the AHCCCS Administration and the PSA harmless from any and all liability arising from the contractor's subcontracts, and shall be responsible for:

1. All costs of defense of any litigation concerning the liability; and
2. Satisfaction in full of any judgment entered against the AHCCCS Administration and the PSA in litigation involving the contractor's subcontracts.

D. Capitation rates. The PSA shall establish actuarially sound capitation rates as specified in Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21. The PSA may adjust the initial capitation rates, except that any increase exceeding 10% of the established rate must 1st be reviewed by the oversight committee as specified in Laws 1997, Ch. 186, § 5.

E. Payments. The PSA shall make all payments to a contractor in accordance with the terms and conditions of the contract executed between the contractor and the PSA and in accordance with these rules.

F. Medical financial risk. The PSA will limit the medical financial risk to contractors associated with the PSDP through a risk sharing reconciliation arrangement as specified in contract.

G. Payments made on behalf of a contractor; recovery of indebtedness. The PSA may make payments on behalf of a contractor in order to prevent a suspension or termination of services as specified in A.A.C. R9-22-713.

H. Specialty contracts and payments. The PSA may at any time negotiate or contract for specialty contracts on behalf of pro-

viders, and noncontracting providers. The PSA and a contractor shall meet the requirements in A.A.C. R9-22-716.

I. Charges against a Premium Share member. A contractor, subcontractor, or other provider of services shall not:
1. Charge;
2. Submit a claim; or
3. Demand or otherwise collect payment from a Premium Share member or person acting on behalf of a Premium Share member for any covered service except to collect an authorized copayment or payment for a noncovered service. A contractor who makes a claim for a noncovered service shall not charge more than the actual, reasonable cost for providing the service.

J. Collecting payment. Except for copayments under R9-30-701(F), a provider shall not bill or make any attempt to collect payment, directly or through a collection agency, from a person claiming to be a Premium Share member without 1st receiving verification from the PSA that the person was ineligible for PSDP on the date of service or that the services provided were not covered by PSDP.

K. Premium Share member withheld information. The prohibition in Section (J) shall not apply if the PSA determines that the Premium Share member willfully withheld information pertaining to the Premium Share member's enrollment with a contractor. A prepaid capitated contractor shall have the right to recover from a Premium Share member that portion of payment made by a 3rd-party to the Premium Share member when the payment duplicates the PSDP benefits and the payment has not been assigned to the contractor.

Historical Note

Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

R9-30-703. Contractor's and Provider's Claims and Payment Responsibilities

A. General responsibilities. A provider shall submit to a contractor all claims for services rendered to a Premium Share member enrolled with the contractor. A contractor shall pay for all admissions and covered services provided to a Premium Share member when the admissions or covered services have been arranged and necessary authorization has been obtained by:
1. A contractor's agent or employee;
2. A subcontracting provider; or
3. Other person acting on the subcontractor's behalf.

B. Claims.
1. Time-frame to pay a claim. A contractor shall reimburse subcontracting and noncontracting providers for the provision of covered services to a Premium Share member either:
   a. Within the time period specified by contract between a contractor and a subcontracting entity; or
   b. Within 60 days of receipt of a clean claim, if a time period is not specified in contract; or
   c. For a hospital claim, a contractor shall pay a noncontracting provider for inpatient hospital and outpatient hospital services according to the quick pay discount and slow pay penalties as specified in A.R.S. § 36-2903.01(J).
2. When a contractor is not required to pay a claim. A contractor is not required to pay a claim for covered services that is submitted more than 6 months after the date of the service, or that is submitted as a clean claim more than 12 months after the date of service.
3. Inpatient or outpatient hospital claim. A contractor shall pay the hospitals in accordance with:
   a. How a hospital claim is processed under A.A.C. R9-22-705;
   b. What personal care items are covered under A.A.C. R9-22-717; and
   c. What hospital supplies and equipment are covered under A.A.C. R9-22-717.
4. Review of hospital claims. If a contractor and a hospital do not agree on reimbursement levels, terms and conditions, the requirements specified in A.A.C. R9-22-705 shall apply.
5. Denial and rights of a claimant. A contractor shall provide written notice to a provider whose claim is denied or reduced by the contractor within 60 days of receipt of a claim. This notice shall include a statement describing the provider's right to:
   a. Grieve the contractor's rejection or reduction of the claim; and
   b. Submit a grievance in accordance with A.A.C. R9-22-804.

C. Reimbursement.
1. In-state inpatient hospital reimbursement. A contractor shall reimburse an in-state subcontractor and noncontracting provider for the provision of inpatient hospital services. The contractor may choose among the following reimbursement methodologies depending on the county in which the services are provided.
   a. Maricopa and Pima counties.
      i. A rate specified by subcontract. Subcontract rates, terms and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and A.A.C. R9-22-715; or
      ii. Reimbursement based on the pilot program described in A.A.C. R9-22-718.
   b. Cochise and Pinal counties.
      i. A rate specified by subcontract. Subcontract rates, terms and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and A.A.C. R9-22-715; or
      ii. The prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and A.A.C. R9-22-712.
2. Payment for emergency services and subsequent care. A contractor shall pay for all emergency care services provided to a Premium Share member by subcontracting and noncontracting providers when a service:
   a. Conforms to the notification requirements in 9 A.A.C. 30, Article 2;
   b. Conforms to the definition of emergency medical services defined in 9 A.A.C. 22, Article 1;
   c. Meets the requirements in A.A.C. R9-22-709 - Contractor's Liability for Hospital for the Provision of Emergency and Subsequent Care; and
   d. Is provided in the most appropriate, cost-effective, and least restrictive setting.
3. Observation days. A contractor may reimburse subcontracting and noncontracting providers for the provision of observation days that do not result in an admission at:
   a. A rate specified by subcontract; or
   b. In the absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered billed charges.
4. Outpatient hospital reimbursement. A contractor shall reimburse subcontracting and noncontracting providers for the provision of outpatient hospital services rendered at either:

a. A rate specified by subcontract. Subcontract rates, terms, and conditions are subject to review, and approval or disapproval under A.R.S. § 36-2904 and A.A.C. R9-22-715; or
b. In the absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered billed charges.

5. Out-of-state hospital reimbursement. A contractor shall reimburse an out-of-state hospital for the provision of inpatient and outpatient hospital services at:
a. The lower of the negotiated discounted rates; or
b. 80% of billed charges.

D. Transfer of payments. The PSA or a contractor shall meet the requirements in A.A.C. R9-22-704.

Historical Note
Adopted under an exemption from the regular rulemaking process effective February 1, 1998; filed with the Office of the Secretary of State January 29, 1998 (Supp. 98-1). Amended by exempt rulemaking at 5 A.A.R. 745, effective February 19, 1999 (Supp. 99-1).

ARTICLE 8. MEMBERS' RIGHTS AND RESPONSIBILITIES

R9-30-801. General Intent and Definitions

A. This Article defines the notice and appeal process when a Premium Share contractor denies, reduces, suspends, or terminates a service and provides a party with the opportunity for an expedited hearing.

B. Definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "Action" means termination, suspension, or reduction of a covered service as defined in R9-30-102.
2. "Contractor" means a health plan, Arizona Department of Health Services, or a Regional Behavioral Health Authority.
3. "Date of action" means the effective date for a termination, suspension, or reduction.
4. "Denial" means the decision not to authorize a requested service.
5. "Notice" means a written statement that meets the requirements specified in R9-30-804.
6. "Party" means a member or contractor.
7. "Request for a hearing" means a clear expression by a Premium Share member or a member's authorized representative that the Premium Share member wants the opportunity to present the Premium Share member's case to a reviewing authority.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

R9-30-802. Denial of a Request for a Service

A Premium Share contractor shall provide a Premium Share member with written notice no later than 3 business days from the date when authorization for a requested service is denied by the party giving notice.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

R9-30-803. Reduction, Suspension, or Termination of a Service

Except as permitted under R9-30-805 and R9-30-806, if the Premium Share contractor reduces, suspends, or terminates a service currently provided by the Premium Share contractor, the Premium Share contractor shall provide the member written Notice of Intended Action at least 10 days prior to the date of the intended action.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

R9-30-804. Content of Notice

A Notice of Intended Action, required under R9-30-802 or R9-30-803 of this Article, shall contain the following:

1. A statement of the action the Premium Share contractor intends to take;
2. The succinct and specific reason for the intended action;
3. The specific law or rule that supports the action;
4. A change in federal or state law that requires an action;
5. An explanation of:
a. A Premium Share member's right to request an evidentiary hearing; and
b. The circumstances under which the Premium Share contractor shall grant a hearing for an action based on a change in the law; and
6. An explanation of the circumstance under which the Premium Share contractor shall continue a covered service if a Premium Share member appeals an action for a:
a. Reduction,
b. Suspension, or
c. Termination of a service.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

R9-30-805. Exceptions from an Advance Notice

A Premium Share contractor may mail a Notice of Intended Action for a reduction, suspension, or termination of a service not later than the date of action if the Premium Share contractor:

1. Has factual information confirming the death of a Premium Share member;
2. Receives a written statement signed by the Premium Share member that:
a. States services are no longer wanted; or
b. Provides information which requires a reduction or a termination of a service and indicates that the Premium Share member understands that a reduction or a termination of a service shall be the result of providing that information;
3. Learns that a Premium Share member has been admitted to an institution which makes the Premium Share member ineligible for further services;
4. Does not know the Premium Share member's whereabouts and mail directed to the Premium Share member is returned by the post office and no forwarding address is provided;
5. Has established the fact that a Premium Share member has been approved for Medicaid;
6. Knows that the Premium Share member's primary care provider has prescribed a change in the level of medical care.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

R9-30-806. Notice in a Case of Probable Fraud

A Premium Share contractor may shorten the advance notice period to 5 days before the date of action if:

1. The circumstances indicate that action should be taken because of probable fraud by a Premium Share member; and
2. The facts have been verified through collateral resources, if possible.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

R9-30-807. Expedited Hearing Process

A. Alternative hearing process. This Section provides an alternative expedited hearing process for denials defined in R9-30-801(B)(4) and an alternative expedited hearing process and continued services for an action defined in R9-30-801(B)(1). Except as stated in this Section, the provisions of 9 A.A.C. 30, Article 6 do not apply. If the PSA determines that a request for hearing filed according to this Section is not timely or not a proper appeal of a denial or action defined in R9-30-801(B), the request for expedited hearing shall instead be considered a grievance according to 9 A.A.C. 30, Article 6 and, if appropriate, forwarded to the Premium Share contractor within 10 business days from the date the PSA receives the request for processing according to 9 A.A.C. 30, Article 6. In this event, services shall not be continued as provided in this Section. If a Premium Share member does not seek continued services or an expedited hearing, the Premium Share member may file a grievance according to 9 A.A.C. 30, Article 6.

B. Time-frames. If the Premium Share contractor denies a service that requires authorization or reduces, suspends, or terminates existing service; and the Premium Share member appeals the action and requests continued services during the hearing process or requests an expedited hearing of a denial for authorization, the Premium Share member must file a request for hearing:

1. No later than 10 business days from the date of personal delivery of the Notice of Intended Action to the Premium Share member; or
2. No later than 15 business days from the postmark date, if mailed, of the Notice of Intended Action.

C. Expedited hearing. A hearing under this Section shall be held no sooner than 20 days and not later than 40 days from the PSA's receipt of the request for hearing. Alternatively, the hearing may be held sooner than 20 days upon the agreement of all of the parties or upon written motion of 1 of the parties establishing, in the discretion of the PSA, extraordinary circumstances or the possibility of irreparable harm if the hearing is not held sooner.

D. Notice of hearing date. The PSA shall provide notice of the hearing date to the Premium Share member or the authorized representative and to all other parties to the appeal.

E. Responsibilities of the PSA or a contractor. The Premium Share contractor shall provide the current level of an existing service during the expedited hearing process, if a request for hearing and request to continue services are properly filed according to this Section.

F. Previously authorized service.

1. If a Premium Share member's primary care provider orders a service that was previously authorized for the Premium Share member, the Premium Share contractor may issue a written denial according to R9-30-802, if the Premium Share contractor considers the request new and independent of any previous authorization. If the Premium Share member's primary care provider asserts that the requested service or treatment is a necessary continuation of the previous authorization, and the member challenges the denial on this basis, then the service shall be continued pending appeal, unless:
   a. The parties reach some other agreement, or
   b. The Premium Share contractor believes the primary care provider's request endangers the Premium Share member.
2. Any dispute regarding reimbursement of a service under this Section is reserved until the provider submits a claim.

G. Responsibility of a Premium Share member. A Premium Share member whose service is continued during the expedited hearing process is financially liable for the service received if the Director upholds the decision to reduce, suspend, or terminate the service.

H. General provisions. The expedited hearing process shall be conducted according to R9-30-601 and R9-22-801, subsections (A) through (E) and (G) through (M).

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

R9-30-808. Maintenance of Records

The Premium Share contractor providing Notice of Intended Action shall maintain records of the written notification and the date of the notice given to the Premium Share member.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

R9-30-809. Member Handbook

A Premium Share contractor shall furnish each Premium Share member with a handbook, as specified in contract, that clearly explains a Premium Share member's right to file a grievance or appeal concerning a denial or action that affects a Premium Share member's receipt of medical services.

Historical Note
Adopted effective September 9, 1998 (Supp. 98-3).

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - CHILDREN'S HEALTH INSURANCE PROGRAM

Editor's Note: Articles 1 through 13, and Article 16 were adopted under an exemption from the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session. Although exempt from certain provisions of the rulemaking process, AHCCCS submitted a notice of docket opening with the Secretary of State for publication in the Arizona Administrative Register. Exemption from A.R.S. Title 41, Chapter 6 means AHCCCS was not required to submit these rules to the Governor's Regulatory Review Council for review; they did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and they were not required to hold public hearings on these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, it is being printed on blue paper.

ARTICLE 1. DEFINITIONS

Article 1, consisting of Sections R9-31-101 thru R9-31-116, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

Section
R9-31-101. Location of Definitions
R9-31-102. Scope of Services Related Definitions
R9-31-103. Eligibility and Enrollment Related Definitions
R9-31-104. Reserved
R9-31-105. General Provisions and Standards
R9-31-106. Request for Proposal (RFP) Related Definitions
R9-31-107. Standards for Payments Related Definitions
R9-31-108. Grievance and Appeals Related Definitions
R9-31-109. Reserved
R9-31-110. 1st- and 3rd- Party Liability and Recoveries Related Definitions
R9-31-111. Reserved
R9-31-112. Covered Behavioral Health Services Related Definitions
R9-31-113. Members' Rights and Responsibilities Related Definitions
R9-31-114. Reserved
R9-31-115. Reserved
R9-31-116. Services for Native Americans Related Definitions

ARTICLE 2. SCOPE OF SERVICES

Article 2, consisting of Sections R9-31-201 thru R9-31-216, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

Section
R9-31-201. General Requirements
R9-31-202. Reserved
R9-31-203. Reserved
R9-31-204. Inpatient General Hospital Services
R9-31-205. Physician and Primary Care Physician and Practitioner Services
R9-31-206. Organ and Tissue Transplantation Services
R9-31-207. Dental Services
R9-31-208. Laboratory, Radiology, and Medical Imaging Services
R9-31-209. Pharmaceutical Services
R9-31-210. Emergency Medical Services
R9-31-211. Transportation Services
R9-31-212. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices
R9-31-213. Health Risk Assessment and Screening Services
R9-31-214. Reserved
R9-31-215. Other Medical Professional Services
R9-31-216. Nursing Facility Services

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

Article 3, consisting of Sections R9-31-301 thru R9-31-310, adopted effective October 23, 1998, under an exemption from the Arizona Administrative Procedure Act. (Supp. 98-4).

Section
R9-31-301. General Requirements
R9-31-302. Applications
R9-31-303. Eligibility Criteria
R9-31-304. Income Eligibility
R9-31-305. Verification
R9-31-306. Enrollment
R9-31-307. Guaranteed Enrollment
R9-31-308. Changes and Redeterminations
R9-31-309. Newborn Eligibility
R9-31-310. Notice Requirements

ARTICLE 4. CONTRACTS

Article 4, consisting of Sections R9-31-401 thru R9-31-407, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

Section
R9-31-401. General Provisions
R9-31-402. Administration's Contracts with Contractors
R9-31-403. Subcontracts
R9-31-404. Contract Amendments; Mergers; Reorganizations
R9-31-405. Suspension, Denial, Modification, or Termination of Contract
R9-31-406. Contract: Sanction; Performance; and Solvency
R9-31-407. Contract or Protest, Appeal

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Article 5, consisting of Sections R9-31-501 thru R9-31-529, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

Section
R9-31-501. General Provisions
R9-31-502. Availability and Accessibility of Service
R9-31-503. Reinsurance
R9-31-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions
R9-31-505. Approval of Advertisements and Marketing Materials
R9-31-506. Reserved
R9-31-507. Member Record
R9-31-508. Limitation of Benefit Coverage for Illness or Injury due to Catastrophe
R9-31-509. Transition and Coordination of Member Care
R9-31-510. Transfer of Members
R9-31-511. Fraud or Abuse
R9-31-512. Release of Safeguarded Information by the Administration and Contractors
R9-31-513. Discrimination Prohibition
R9-31-514. Equal Opportunity
R9-31-515. Reserved
R9-31-516. Reserved
R9-31-517. Reserved

R9-31-518. Information to Enrolled Members
R9-31-519. Reserved
R9-31-520. Financial Statements, Periodic Reports and Information
R9-31-521. Program Compliance Audits
R9-31-522. Quality Management/Utilization Management (QM/UM) Requirements
R9-31-523. Financial Resources
R9-31-524. Continuity of Care
R9-31-525. Reserved
R9-31-526. Reserved
R9-31-527. Reserved
R9-31-528. Reserved
R9-31-529. Reserved

ARTICLE 6. REQUEST FOR PROPOSAL (RFP)

Article 6, consisting of Section R9-31-601, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

Section
R9-31-601. General Provisions for RFP

ARTICLE 7. STANDARDS FOR PAYMENTS

Article 7, consisting of Sections R9-31-701 thru R9-31-717, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

Section
R9-31-701. General; Scope of the Administration's Liability; and Payment to a Contractor
R9-31-702. Prohibitions against Charges to Members
R9-31-703. Claims
R9-31-704. Transfer of Payments
R9-31-705. Payments by Contractors
R9-31-706. Reserved
R9-31-707. Payments for Newborns
R9-31-708. Reserved
R9-31-709. Contractor's Liability to Hospitals for the Provision of Emergency and Subsequent Care
R9-31-710. Reserved
R9-31-711. Copayments
R9-31-712. Reserved
R9-31-713. Payments Made on Behalf of a Contractor; Recovery of Indebtedness
R9-31-714. Reserved
R9-31-715. Hospital Rate Negotiations
R9-31-716. Specialty Contracts
R9-31-717. Hospital Claims Review

ARTICLE 8. GRIEVANCE AND APPEAL PROCESS

Article 8, consisting of Sections R9-31-801 thru R9-31-804, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

Section
R9-31-801. General Provisions for All Grievances and Appeals
R9-31-802. Eligibility Appeals and Hearing Requests for an Applicant and a Member
R9-31-803. Grievances
R9-31-804. Grievance and Appeal Process for Behavioral Health

ARTICLE 9. QUALITY CONTROL

Article 9, consisting of Section R9-31-901, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

Section
R9-31-901. General Provisions

ARTICLE 10. 1ST- AND 3RD-PARTY LIABILITY AND RECOVERIES

Article 10, consisting of Sections R9-31-1001 and R9-31-1002, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

Section
R9-31-1001. 1st- and 3rd-Party Liability and Coordination of Benefits
R9-31-1002. 1st- and 3rd-Party Liability Monitoring and Compliance

ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS

Article 11, consisting of Sections R9-31-1101 thru R9-31-1104, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

Section
R9-31-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims
R9-31-1102. Determinations Regarding the Amount of the Penalty and Assessment
R9-31-1103. Notice of Proposed Determination and Rights of Parties
R9-31-1104. Issues and Burden of Proof

ARTICLE 12. COVERED BEHAVIORAL HEALTH SERVICES

Article 12, consisting of Sections R9-31-1201 thru R9-31-1207, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

Section
R9-31-1201. General Requirements
R9-31-1202. Inpatient Behavioral Health Services
R9-31-1203. Partial Care
R9-31-1204. Outpatient Services
R9-31-1205. Behavioral Health Emergency and Crisis Stabilization Services
R9-31-1206. Other Behavioral Health Services
R9-31-1207. Transportation Services

ARTICLE 13. MEMBERS' RIGHTS AND RESPONSIBILITIES

Article 13, consisting of Sections R9-31-1301 thru R9-31-1309, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

Section
R9-31-1301. General Provisions
R9-31-1302. Denial of a Request for a Service
R9-31-1303. Reduction, Suspension, or Termination of a Service
R9-31-1304. Content of Notice
R9-31-1305. Exceptions from an Advance Notice
R9-31-1306. Notice in a Case of Probable Fraud
R9-31-1307. Expedited Hearing Process
R9-31-1308. Maintenance of Records
R9-31-1309. Member Handbook

ARTICLE 14. RESERVED

ARTICLE 15. RESERVED

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

Article 16, consisting of Sections R9-31-1601 thru R9-31-

1625, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

Section
R9-31-1601. General Requirements
R9-31-1602. General Requirements for Scope of Services
R9-31-1603. Inpatient General Hospital Services
R9-31-1604. Physician and Primary Care Physician and Practitioner Services
R9-31-1605. Organ and Tissue Transplantation Services
R9-31-1606. Dental Services
R9-31-1607. Laboratory, Radiology, and Medical Imaging Services
R9-31-1608. Pharmaceutical Services
R9-31-1609. Emergency Services
R9-31-1610. Transportation Services
R9-31-1611. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices
R9-31-1612. Health Risk Assessment and Screening Services
R9-31-1613. Other Medical Professional Services
R9-31-1614. Nursing Facility Services
R9-31-1615. Eligibility and Enrollment
R9-31-1616. Standards for Payments
R9-31-1617. Prior Authorization
R9-31-1618. Claims
R9-31-1619. Hospital Claims Review
R9-31-1620. Prohibitions Against Charges to Members
R9-31-1621. Transfer of Payments
R9-31-1622. The Administration's Liability to Hospitals for the Provision of Emergency and Subsequent Care
R9-31-1623. Copayments
R9-31-1624. Specialty Contracts
R9-31-1625. Behavioral Health Services

ARTICLE 1. DEFINITIONS

R9-31-101. Location of Definitions

A. For purposes of this Article the term member shall be substituted for the term eligible person.

B. Location of definitions. Definitions applicable to A.A.C. Title 9, Chapter 31 are found in the following.

	Definition	Section or Citation
1.	"1st party liability"	R9-22-110
2.	"3rd party"	R9-22-110
3.	"3rd party liability"	R9-22-110
4.	"Accommodation"	R9-22-107
5.	"Action"	R9-31-113
6.	"Acute mental health services"	R9-22-112
7.	"Administration"	R9-31-101
8.	"Aggregate"	R9-22-107
9.	"AHCCCS"	R9-31-101
10.	"AHCCCS hearing officer"	R9-22-108
11.	"Ambulance"	R9-22-102
12.	"Ancillary department"	R9-22-107
13.	"Appeal"	R9-22-108
14.	"Appellant"	R9-31-108
15.	"Applicant"	R9-31-101
16.	"Application"	R9-31-101
17.	"ADHS"	R9-31-112
18.	"Behavioral health professional"	R9-31-112
19.	"Behavioral health services"	R9-31-112
20.	"Behavioral health technician"	R9-31-112
21.	"Billed charges"	R9-22-107
22.	"Capital costs"	R9-22-107
23.	"Case management"	R9-31-112
24.	"Certified nurse practitioner"	R9-31-102
25.	"Certified psychiatric nurse practitioner"	R9-31-112
26.	"Child"	42 U.S.C. 1397jj
27.	"Clean claim"	A.R.S. § 36-2904
28.	"CMDP"	R9-31-103
29.	"Continuous stay"	R9-22-101
30.	"Contract"	R9-22-101
31.	"Contractor"	R9-31-101
32.	"Contract year"	R9-31-101
33.	"Copayment"	R9-22-107
34.	"Cost avoidance"	R9-31-110
35.	"Cost-to-charge ratio"	R9-22-107
36.	"Covered charges"	R9-31-107
37.	"Covered services"	R9-22-102
38.	"CPT"	R9-22-107
39.	"CRS"	R9-31-103
40.	"Date of action"	R9-31-113
41.	"Day"	R9-22-101
42.	"Denial"	R9-31-113
43.	"Dentures"	R9-22-102
44.	"DES"	R9-31-103
45.	"Determination"	R9-31-103
46.	"Diagnostic services"	R9-22-102
47.	"Director"	A.R.S. § 36-2981
48.	"DME"	R9-22-102
49.	"DRI inflation factor"	R9-22-107
50.	"EAC"	A.R.S. § 36-2905.03(B)
51.	"ELIC"	A.R.S. § 36-2905.03(C) and (D)
52.	"Emergency medical condition"	42 U.S.C. 1396(v)
53.	"Emergency medical services"	R9-22-102
54.	"Encounter"	R9-22-107
55.	"Enrollment"	R9-31-103
56.	"Facility"	R9-22-101
57.	"Factor"	R9-22-101
58.	"FPL"	A.R.S. § 36-2981
59.	"Grievance"	R9-22-108
60.	"Group Health Plan"	42 U.S.C. 1397jj
61.	"GSA"	R9-22-101
62.	"Guardian"	R9-22-103
63.	"Health plan"	A.R.S. § 36-2981
64.	"Hearing aid"	R9-22-102
65.	"Home health services"	R9-22-102
66.	"Hospital"	R9-22-101
67.	"Household income"	R9-31-103
68.	"ICU"	R9-22-107
69.	"IGA"	R9-31-116
70.	"IHS"	R9-31-116
71.	"IHS or Tribal Facility Provider"	R9-31-116
72.	"Inmate of a public institution"	42 CFR 435.1009
73.	"Inpatient hospital services"	R9-31-101
74.	"License or licensure"	R9-22-101
75.	"Medical record"	R9-22-101
76.	"Medical review"	R9-31-107
77.	"Medical services"	R9-22-101
78.	"Medical supplies"	R9-22-102
79.	"Medically necessary"	R9-22-101
80.	"Member"	A.R.S. § 36-2981
81.	"MI/MN"	A.R.S. § 36-2901(4)(a) and (c)
82.	"New hospital"	R9-22-107
83.	"NF"	42 U.S.C. 1396r(a)
84.	"NICU"	R9-22-107
85.	"Noncontracting provider"	A.R.S. § 36-2981
86.	"Occupational therapy"	R9-22-102
87.	"Offeror"	R9-31-106
88.	"Operating costs"	R9-22-107

89.	"Outlier"	R9-31-107
90.	"Outpatient hospital service"	R9-22-107
91.	"Ownership change"	R9-22-107
92.	"Peer group"	R9-22-107
93.	"Pharmaceutical service"	R9-22-102
94.	"Physical therapy"	R9-22-102
95.	"Physician"	A.R.S. § 36-2981
96.	"Post stabilization services	42 CFR 438.114
97.	"Practitioner"	R9-22-102
98.	"Pre-existing condition"	R9-31-105
99.	"Prepaid capitated"	A.R.S. § 36-2981
100.	"Prescription"	R9-22-102
101.	"Primary care physician"	A.R.S. § 36-2981
102.	"Primary care practitioner"	A.R.S. § 36-2981
103.	"Primary care provider"	R9-22-102
104.	"Primary care provider services"	R9-22-102
105.	"Prior authorization"	R9-22-102
105.	"Private duty nursing services"	R9-22-102
107.	"Program"	A.R.S. § 36-2981
108.	"Proposal"	R9-31-106
109.	"Prospective rates"	R9-22-107
110.	"Prudent layperson standard"	42 U.S.C. 1396u-2
111.	"PSP"	R9-31-103
112.	"Psychiatrist"	R9-31-112
113.	"Psychologist"	R9-31-112
114.	"Qualified alien"	P.L. 104-193
115.	"Qualifying Health Center"	A.R.S. § 36-2981
116.	"Qualifying plan"	A.R.S. § 36-2981
117.	"Quality management"	R9-22-105
118.	"Radiology services"	R9-22-102
119.	"Rebasing"	R9-22-107
120.	"Redetermination"	R9-31-103
121.	"Referral"	R9-22-101
122.	"RBHA"	R9-31-112
123.	"Rehabilitation services"	R9-22-102
124.	"Reinsurance"	R9-22-107
125.	"Request for hearing"	R9-31-108
126.	"RFP"	R9-31-106
127.	"Respiratory therapy"	R9-22-102
128.	"Respondent"	R9-31-108
129.	"Scope of services"	R9-22-102
130.	"SDAD"	R9-22-107
131.	"SMI"	A.R.S. § 36-550
132.	"Service location"	R9-22-101
133.	"Service site"	R9-22-101
134.	"Specialist"	R9-22-102
135.	"Speech therapy"	R9-22-102
136.	"Spouse"	R9-31-103
137.	"SSI-MAO"	R9-31-103
138.	"Sterilization"	R9-22-102
139.	"Subcontract"	R9-22-101
140.	"Substance abuse"	R9-31-112
141.	"TRBHA"	R9-31-116
142.	"Tier"	R9-22-107
143.	"Tiered per diem"	R9-31-107
144.	"Title XIX"	42 U.S.C. 1396
145.	"Title XXI"	42 U.S.C. 1397jj
146.	"Treatment"	R9-31-112
147.	"Tribal facility"	A.R.S. § 36-2981
148.	"Utilization management"	R9-22-105

C. General definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "Administration" means the Arizona Health Care Cost Containment System, its agents, employees and designated representatives.
2. "AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.
3. "Applicant" means a person who submits, or on whose behalf is submitted, a written, signed, and dated application for Title XXI benefits which has not been completed or denied.
4. "Application" means an official request for Title XXI benefits made in accordance with Article 3.
5. "Contractor" means a health plan that contracts with the Administration for the provision of hospitalization and medical care to members according to the provisions of this Article or a qualifying plan.
6. "Contract year" means the date beginning on October 1 and continuing until September 30 of the following year.
7. "Inpatient hospital services" means medically necessary services that require an inpatient stay in an acute hospital. Inpatient hospital services are provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-102. Scope of Services Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning: "Certified nurse practitioner" means a registered nurse practitioner as certified by the Arizona Board of Nursing according to A.R.S. Title 32, Chapter 15.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-103. Eligibility and Enrollment Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "CMDP" means Children's Medical and Dental Program.
2. "CRS" means Children's Rehabilitative Services.
3. "DES" means the Department of Economic Security.
4. "Determination" means the process by which an applicant is approved or denied for coverage.
5. "Enrollment" means the process by which a person is determined eligible for and enrolled in the program.
6. "Household income" means the total gross amount of all money received by or directly deposited into a financial account of a member of the household income group as defined in R9-31-309.
7. "PSP" means Premium Sharing Project, which is a 3-year pilot program established according to A.R.S. § 36-2923.
8. "Redetermination" means the periodic review of a member's continued Title XXI eligibility.
9. "Spouse" means the husband or wife of a Title XXI applicant or household member, who has entered into a contract of marriage, recognized as valid by Arizona.
10. "SSI-MAO" means Supplemental Security Income-Medical Assistance Only.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chap-

ter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-104. Reserved

R9-31-105. General Provisions and Standards

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning: "Pre-existing condition" means an illness or injury that is diagnosed or treated within a 6-month period preceding the effective date of coverage.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-106. Request for Proposal (RFP) Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "Offeror" means a person or other entity which may submit a proposal to the Administration in response to a Request for Proposals.
2. "Proposal" means all documents including best and final offers submitted by an offeror in response to a Request for Proposals by the Administration.
3. "RFP" means Request for Proposals of all documents, whether attached or incorporated by reference, which are used by the Administration for soliciting a proposal according to this Article.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-107. Standards for Payments Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "Covered charges" means billed charges that represent medically necessary, reasonable, and customary items of expense for Title XXI covered services that meet medical review criteria of the Administration or contractor.
2. "Medical review" means a review involving clinical judgment of a claim or a request for a service before or after it is paid or rendered to ensure that services provided to a member are medically necessary and covered services and that required authorizations are obtained by the provider. The criteria for medical review are established by the contractor based on medical practice standards that are updated periodically to reflect changes in medical care.
3. "Outlier" means a hospital claim or encounter in which the Title XXI inpatient hospital days of care have operating costs per day that meet the criteria described in A.A.C. R9-22-712.
4. "Tiered per diem" means a payment structure in which payment is made on a per-day basis depending upon the tier into which the Title XXI inpatient hospital day of care is assigned.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-108. Grievance and Appeal Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "Appellant" means an individual filing any grievance or appeal under this Article.
2. "Request for hearing" means an appeal of an adverse eligibility action; an appeal filed after an informal decision has been rendered on a grievance by the Administration; an appeal of a grievance decision rendered by a contractor; or an appeal filed because a contractor has failed to render a timely grievance decision.
3. "Respondent" means the party responsible for the action being grieved or appealed. In Title XXI eligibility appeals, the Administration is the respondent. In most member grievances, the contractor generally is the respondent.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-109. Reserved

R9-31-110. 1st- and 3rd-Party Liability and Recoveries Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning: "Cost avoidance" means avoiding payment of claims when 1st- or 3rd-party payment sources are available.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-111. Reserved

R9-31-112. Covered Behavioral Health Services Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "ADHS" means the Arizona Department of Health Services which is the department mandated to serve the public health needs of all Arizona residents.
2. "Behavioral health professional" means a psychiatrist, psychologist, social worker, counselor, certified nurse practitioner, registered nurse, or physician's assistant who meets appropriate licensure requirements or certification requirements.
3. "Behavioral health services" means those Title XXI covered and medically necessary treatment services for behavioral health or substance abuse disorders as specified in this Chapter.
4. "Behavioral health technician" means an individual with a:
   a. Bachelor's degree in a behavioral health-related field;
   b. Bachelor's degree in any field, plus 1 year of experience in a behavioral health service delivery;
   c. A high school diploma or GED and a combination of behavioral health education and experience totaling 4 years. Behavioral health technicians shall be supervised by a behavioral health professional or a clinical supervisor.
5. "Case management" means a supportive service to enhance treatment compliance and effectiveness. Case management services may be telephonic, may vary in fre-

quency and intensity based on member need, and are ordered by or provided by or under the clinical supervision of the assigned behavioral health professional.

6. "Certified psychiatric nurse practitioner" means a registered nurse certified by the Arizona Board of Nursing in A.R.S. Title 32, Chapter 15 as having a specialty in psychiatric care. Only a certified psychiatric nurse practitioner with a psychiatric and mental health certification may bill for covered behavioral health services.
7. "Psychiatrist" means a psychiatrist who is professionally licensed according to A.R.S. Title 32, Chapter 13 or Chapter 17, Board certified or Board eligible under the standards of the American Board of Psychiatry and Neurology or the Osteopathic Board of Neurology and Psychiatry.
8. "Psychologist" means a person who is licensed by the Arizona Board of Psychologist Examiners according to A.R.S. Title 32, Chapter 19.1.
9. "RBHA" means the Regional Behavioral Health Authority which is an organization under contract with ADHS to coordinate the delivery of behavioral health services in a geographically specific service area of the state.
10. "Substance abuse" means the chronic, habitual or compulsive use of any chemical matter which, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological or physiological dependence and/or impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse.
11. "Treatment" means the range of behavioral health care received by a member that is consistent with the therapeutic goals outlined in the individual service plan.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-113. Members' Rights and Responsibilities Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "Action" means a termination, suspension, or reduction of a covered service for the purposes of 9 A.A.C. 31, Article 13 only.
2. "Date of action" means the intended date on which a termination, suspension, or reduction becomes effective for the purposes of 9 A.A.C. 31, Article 13 only.
3. "Denial" means the decision not to authorize a requested service for the purposes of 9 A.A.C. 31, Article 13 only.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-114. Reserved

R9-31-115. Reserved

R9-31-116. Services for Native Americans Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "IGA" means Intergovernmental Agreement.
2. "IHS" means Indian Health Service.
3. "IHS or Tribal Facility Provider" means a person who is authorized by the IHS or Tribal Facility and registered as an AHCCCS provider to provide covered services to members. The IHS or Tribal Facility by authorizing the person to provide covered services, shall certify that the person meets all applicable federal and state requirements.
4. "TRBHA" means the Tribal Regional Behavioral Health Authority. Tribal governments, through an IGA with ADHS may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to a Native American member residing on reservation.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

ARTICLE 2. SCOPE OF SERVICES

R9-31-201. General Requirements

A. The Administration shall administer the program specified in A.R.S. § 36-2982.

B. The Director has full operational authority to adopt rules or to use the appropriate rules adopted as specified in A.R.S. § 36-2986.

C. Behavioral health services shall be provided as specified in 9 A.A.C. 31, Article 12.

D. In addition to requirements and limitations specified in this Chapter, the following general requirements apply:

1. As specified in A.R.S. § 36-2989, covered services provided to a member shall be medically necessary and provided by, or under the direction of, a primary care provider or a dentist; specialist services shall be provided under referral from, and in consultation with, the primary care provider.
   a. The role or responsibility of a primary care provider, as defined in these rules, shall not be diminished by the primary care provider delegating the provision of primary care for a member to a practitioner, and
   b. The contractor may waive the referral requirements;
2. Services shall be rendered in accordance with state and federal laws and regulations, the *Arizona Administrative Code*, and AHCCCS contractual requirements;
3. Experimental services as determined by the Director, or services provided primarily for the purpose of research, shall not be covered;
4. Services or items, if furnished gratuitously, are not covered and payment shall be denied;
5. Personal care items are not covered and payment shall be denied;
6. Services shall not be covered if provided to:
   a. An inmate of a public institution,
   b. A person who is a resident of an institution for the treatment of tuberculosis, or
   c. A person who is in an institution for the treatment of mental diseases at the time of application.

E. Services shall be provided by AHCCCS registered personnel or facilities, that meet state and federal requirements, and are appropriately licensed or certified to provide the services.

F. Payment for services or items requiring prior authorization may be denied if prior authorization by the contractor is not obtained. Emergency services do not require prior authorization.

1. Services for unrelated conditions, requiring additional diagnostic and treatment procedures, require additional prior authorization.
2. In addition to the requirements of 9 A.A.C. 31, Article 7, written documentation of diagnosis and treatment is

required for reimbursement of services that require prior authorization.

G. As specified in A.R.S. § 36-2989, covered services rendered to a member shall be provided within the service area of the member's primary contractor except when:
1. A primary care provider refers a member out of the contractor's area for medical specialty care;
2. A covered service that is medically necessary for a member is not available within the contractor's service area;
3. A net savings in service delivery costs can be documented without requiring undue travel time or hardship for a member or the member's family;
4. A member is placed in a nursing facility located out of the contractor's service area; and
5. The service is otherwise authorized by the contractor based on medical practice patterns, and cost or scope of service considerations.

H. When a member is traveling or temporarily residing out of the service area of the member's contractor, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

I. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in these rules and in contract.

J. If a member requests the provision of a service that is not covered by a contractor or not authorized by a contractor, the service may be rendered to a member by an AHCCCS-registered service provider under the following conditions:
1. A document that lists the requested services and the itemized cost of each is prepared by the contractor and provided to the member; and
2. The signature of the member is obtained in advance of service provision indicating that the services have been explained to the member and that the member accepts responsibility for payment.

K. If a member is referred out of a contractor's service area to receive an authorized medically necessary service for an extended period of time, a contractor shall also provide all other medically necessary covered services for a member during that time.

L. The restrictions, limitations, and exclusions in this Article shall not apply to contractors when electing to provide noncovered services.
1. The costs associated with providing any noncovered service to a member shall not be included in development or negotiation of capitation.
2. Noncovered services shall be paid from administrative revenue or other contractor funds, unrelated to Title XXI services.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-202. Reserved

R9-31-203. Reserved

R9-31-204. Inpatient General Hospital Services

Inpatient services provided in a general hospital shall be covered by contractors or noncontracting providers and shall include:
1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
   a. Maternity care,
   b. Neonatal intensive care (NICU),
   c. Intensive care (ICU),
   d. Surgery,
   e. Nursery,
   f. Routine care, and
   g. Behavioral health (psychiatric) care as specified in A.R.S. § 36-2989 and 9 A.A.C. 31, Article 12.
2. Ancillary services as specified by the Director and included in contract:
   a. Labor, delivery and recovery rooms, and birthing centers;
   b. Surgery and recovery rooms;
   c. Laboratory services;
   d. Radiological and medical imaging services;
   e. Anesthesiology services;
   f. Rehabilitation services;
   g. Pharmaceutical services and prescribed drugs;
   h. Respiratory therapy;
   i. Blood and blood derivatives;
   j. Central supply items, appliances, and equipment not ordinarily furnished to all patients and which are customarily reimbursed as ancillary services;
   k. Maternity services; and
   l. Nursery and related services.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-205. Physician and Primary Care Physician and Practitioner Services

A. Primary care provider services shall be furnished by a physician or practitioner and shall be covered for members when rendered within the provider's scope of practice under A.R.S. § 36-2981. Primary care provider services may be provided in an inpatient or outpatient setting and shall include at a minimum:
1. Periodic health examinations and assessments,
2. Evaluations and diagnostic workups,
3. Medically necessary treatment,
4. Prescriptions for medications and medically necessary supplies and equipment,
5. Referrals to specialists or other health care professionals when medically necessary as specified in A.R.S. § 36-2989,
6. Patient education,
7. Home visits when determined medically necessary,
8. Covered immunizations, and
9. Covered preventive health services.

B. As specified in A.R.S. § 36-2989, a 2nd opinion procedure may be required to determine coverage for surgeries. Under this procedure, documentation must be provided by at least 2 physicians as to the need for the proposed surgery.

C. The following limitations and exclusions apply to physician and practitioner services and primary care provider services:
1. Specialty care and other services provided to a member upon referral from a primary care provider shall be limited to the services or conditions for which the referral is made, or for which authorization is given, unless referral is waived by the contractor.
2. If a physical examination is performed with the primary intent to accomplish 1 or more of the objectives listed in subsection (A), it shall be covered by the member's contractor except if there is an additional or alternative objective to satisfy the demands of an outside public or private agency. Alternative objectives may include physical examinations and resulting documentation for:
   a. Qualification for insurance,
   b. Pre-employment physical evaluation,

c. Qualification for sports or physical exercise activities,
d. Pilot's examination (FAA),
e. Disability certification for establishing any kind of periodic payments,
f. Evaluation for establishing 3rd party liabilities, or
g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection (A).

4. The following services shall be excluded from Title XXI coverage:
a. Infertility services, reversal of surgically induced infertility (sterilization), and sex change operations;
b. Abortion counseling services;
c. Abortions, unless authorized under federal law;
d. Services or items furnished solely for cosmetic purposes; and
e. Hysterectomies, unless determined to be medically necessary.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-206. Organ and Tissue Transplantation Services
The following organ and tissue transplantation services shall be covered for a member as specified in A.R.S. § 36-2989 if prior authorized and coordinated with a member's contractor:

1. Kidney transplantation;
2. Simultaneous Kidney/Pancreas transplant;
3. Cornea transplantation;
4. Heart transplantation;
5. Liver transplantation;
6. Autologous and allogeneic bone marrow transplantation;
7. Lung transplantation;
8. Heart-lung transplantation;
9. Other organ transplantation if the transplantation is required by federal law and if other statutory criteria are met; and
10. Immunosuppressant medications, chemotherapy, and other related services.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-207. Dental Services
Medically necessary dental services shall be provided for children under age 19 as specified in A.R.S. § 36-2989.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-208. Laboratory, Radiology, and Medical Imaging Services
As specified in A.R.S. § 36-2989, laboratory, radiology, and medical imaging services shall be covered services if:

1. Prescribed for members by a primary care provider or a dentist, or if prescribed by a physician or practitioner upon referral from the primary care provider or dentist, unless referral is waived by the contractor;
2. Provided in hospitals, clinics, physician offices, or other health care facilities by licensed health care providers; and
3. Provided by a provider that meets all applicable state and federal license and certification requirements and provides only services that are within the scope of practice stated in the provider's license or certification.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-209. Pharmaceutical Services

A. Pharmaceutical services may be provided by an inpatient or outpatient provider including hospitals, clinics, or appropriately licensed health care facilities and pharmacies.

B. The contractor shall make pharmaceutical services available during customary business hours and shall be located within reasonable travel distance of a member's residence.

C. As specified in A.R.S. § 36-2989, pharmaceutical services shall be covered if prescribed for a member by the member's primary care provider or dentist, or if prescribed by a specialist upon referral from the primary care provider, unless referral is waived by the contractor or its designee.

D. The following limitations shall apply to pharmaceutical services:
1. A medication personally dispensed by a physician or dentist is not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
2. A prescription in excess of a 30 day supply or a 100-unit dose is not covered unless:
a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is more.
b. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.
c. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 days or 100-unit dose, whichever is more.
3. A nonprescription medication is not covered unless an appropriate alternative over the counter medication is available and less costly than a prescription medication.
4. A prescription is not covered if filled or refilled in excess of the number specified, or if an initial prescription or refill as dispensed after 1 year from the original prescribed order.
5. Approval by the authorized prescriber is required for all changes in, or additions to, an original prescription. The date of a prescription change is to be clearly indicated and initialed by the dispensing pharmacist.

E. A contractor shall monitor and take necessary actions to ensure that a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being, is provided sufficient services to eliminate any gap in the required pharmaceutical regimen.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-210. Emergency Medical Services

A. Emergency medical services shall be provided based on the prudent layperson standard to a member by licensed providers registered with AHCCCS to provide services as specified in A.R.S. § 36-2989.

B. The provider of emergency services shall verify eligibility and enrollment status through the Administration to determine the need for notification to a contractor or a RBHA for a member and to determine the party responsible for payment of services rendered.

C. Access to an emergency room and emergency medical services shall be available 24 hours per day, 7 days per week in each contractor's service area. The use of examining or treatment rooms shall be available when required by a physician or practitioner for the provision of emergency services.

D. Consultation provided by a psychiatrist or psychologist shall be covered as an emergency service, so long as it meets the requirements of 9 A.A.C. 31, Article 12.

E. Emergency services do not require prior authorization but providers shall comply with the following notification requirements:
1. Providers, nonproviders, and noncontracting providers furnishing emergency services to a member shall notify the member's contractor within 12 hours of the time the member presents for services;
2. If a member's medical condition is determined not to be an emergency medical condition, as defined in Article 1 of this Chapter, the provider shall notify the member's contractor before initiation of treatment and follow the prior authorization requirements and protocol of the contractor regarding treatment of the member's nonemergent condition. Failure to provide timely notice or comply with prior authorization requirements of the contractor constitutes cause for denial of payment.

F. A provider, a nonprovider, and a noncontracting provider shall request authorization from a contractor for post stabilization services. A contractor shall pay for the post stabilization services if:
1. The service is pre-approved by a contractor, or
2. A contractor does not respond to an authorization request within the time-frame specified in 42 CFR 438.114, as of September 29, 1998, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-211. Transportation Services

A. Emergency ambulance services.
1. As specified in A.R.S. § 36-2989, emergency ambulance transportation services shall be a covered service for a member. Payment shall be limited to the cost of transporting the member in a ground or air ambulance:
   a. To the nearest appropriate provider or medical facility capable of meeting the member's medical needs; and
   b. When no other means of transportation is both appropriate and available.
2. A ground or air ambulance transport that originates in response to a 911 call or other emergency response system shall be reimbursed by the member's contractor if the medical condition at the time of transport justified a medically necessary ambulance transport. No prior authorization is required for reimbursement of these transports.
3. Determination of whether transport is medically necessary shall be based upon the medical condition of the member at the time of transport.
4. A ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure to notify the contractor may constitute cause for denial of claims.

B. Air ambulance services shall be covered only if:
1. The air ambulance transport is initiated upon the request of an emergency response unit, a law enforcement official, a hospital or clinic medical staff member, a physician, or a practitioner;
2. The point of pickup is inaccessible by ground ambulance, or great distances, or other obstacles are involved in getting emergency services to the member or transporting the member to the nearest hospital or other provider with appropriate facilities; and
3. The medical condition of the member requires timely ambulance service and ground ambulance service will not suffice.

C. Medically necessary patient transfers provided by an emergency air or ground transportation provider may be covered when a member receiving inpatient services requires transport to another level of care or requires round trip transport to another facility to obtain necessary specialized diagnostic treatment services if:
1. A member's condition is such that the use of any other method of transportation would be harmful to a member's health, and
2. Services are not available in the facility where a member is a patient.

D. Meals, lodging and escort services.
1. Expenses for meals and lodging for a member while en route to, or returning from, an approved and prior authorized health care service site out of a member's service area or county of residence shall be a Title XXI covered service.
2. Expenses of an escort, who may be a family household member accompanying a member out of a member's service area shall be covered if the services of the escort are ordered in writing by a member's primary care provider, attending physician or practitioner.

E. Limitations.
1. Expenses shall be allowed only when a member requires a covered service that is not available in the service area;
2. If a member is admitted to an inpatient facility, expenses for the escort shall be covered only when accompanying a member en route to, and returning from, the inpatient facility; and
3. A salary for an escort shall be covered if an escort is not a part of a member's family household.

F. Non-emergency transportation services are not covered as specified in A.R.S. § 36-2989.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-212. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices

A. As specified in A.R.S. § 36-2989, medical supplies, durable equipment, and orthotic and prosthetic devices shall be covered services if:
1. Prescribed for a member by the member's primary care provider or if prescribed by a physician or practitioner upon referral from the primary care provider unless referral is waived by the contractor, or

2. Provided in compliance with requirements of this Chapter.

B. Medical supplies include consumable items covered under Medicare that are provided to a member and that are not reusable.

C. Medical equipment includes any durable item, appliance, or piece of equipment that is designed for a medical purpose, is generally reusable by others, and is purchased or rented for a member.

D. Prosthetic and orthotic devices include only those items that are essential for the habilitation or rehabilitation of a member.

E. The following limitations apply:
1. If medical equipment can not be obtained from alternative resources at no cost, the medical equipment shall be furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the equipment shall not exceed the cost of the equipment if purchased.
2. Reasonable repair or adjustment of purchased medical equipment shall be covered if necessary to make the equipment serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.
3. Changes in, or additions to, an original order for medical equipment shall be approved by the member's primary care provider or authorized prescriber, or prior authorized by the contractor for members, and shall be indicated clearly and initialed by the vendor. No change or addition to the original order for medical equipment shall be made after a claim for services has been submitted to a member's contractor, without prior written notification of the change or addition.
4. Rental fees shall terminate:
   a. No later than the end of the month in which the primary care provider or authorized prescriber certifies that the member no longer needs the medical equipment;
   b. When the member is no longer eligible for Title XXI services; or
   c. When the member is no longer enrolled with a contractor, with the exception of transitions of care as specified by the Director.
5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming shall not be covered unless needed to treat a medical condition and provided in accordance with a prescription.
6. First aid supplies shall not be covered unless they are provided in accordance with a prescription.

F. Liability and ownership.
1. Purchased durable medical equipment provided to a member but which is no longer needed may be disposed of in accordance with each contractor's policy.
2. If customized durable medical equipment is purchased by the contractor for a member, the equipment will remain with the member during times of transition, or upon loss of eligibility.
   a. For purposes of this Section, customized durable medical equipment refers to equipment that has been altered or built to specifications unique to a member's medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.
   b. Customized equipment obtained fraudulently by a member shall be returned for disposal to the member's contractor.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-213. Health Risk Assessment and Screening Services

A. As specified in A.R.S. § 36-2989, the following services shall be covered for a member less than 19 years of age:
1. Screening services, including:
   a. Comprehensive health, behavioral health and developmental histories;
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations according to age and health history; and
   d. Health education, including anticipatory guidance.
2. Vision services as specified in A.R.S. § 36-2989 including:
   a. Treatment for medical conditions of the eye,
   b. 1 eye examination per contract year, and
   c. Provision of 1 pair of prescriptive lenses per contract year.
3. Hearing services, including:
   a. Diagnosis and treatment for defects in hearing;
   b. Testing to determine hearing impairment; and
   c. Provision of hearing aids.

B. All providers of services shall meet the following standards:
1. Provide services by or under the direction of, the member's primary care provider or dentist.
2. Perform tests and examinations in accordance with the AHCCCS Administration Periodicity Schedule.
   a. Refer members as necessary for dental diagnosis and treatment, and necessary specialty care.
   b. Refer members as necessary for behavioral health evaluation and treatment services as specified in 9 A.A.C. 31, Article 12.

C. Contractors shall meet the following additional conditions for members:
1. Provide information to members and their parents or guardians concerning services;
2. Notify members and their parents or guardians regarding the initiation of screening and subsequent appointments according to the AHCCCS Administration Periodicity Schedule; and

D. Members with special health care needs may be referred to the Children's Rehabilitative Service program.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-214. Reserved

R9-31-215. Other Medical Professional Services

A. The following medical professional services provided to a member by a contractor shall be covered services when provided in an inpatient, outpatient, or office setting within limitations specified below:
1. Dialysis;
2. Family planning services as specified in A.R.S. § 36-2989 including medications, supplies, devices, and surgical procedures provided to delay or prevent pregnancy. Family planning services are limited to:
   a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
   b. Natural family planning education or referral;
3. Certified nurse midwife services provided by a certified nurse practitioner in midwifery;

4. Podiatry services when ordered by a member's primary care provider as specified in A.R.S. § 36-2989;
5. Respiratory therapy;
6. Ambulatory and outpatient surgery facilities services;
7. Home health services in A.R.S. § 36-2989;
8. Private or special duty nursing services when medically necessary and prior authorized;
9. Rehabilitation services including physical therapy, occupational therapy, audiology and speech therapy within limitations in this Article;
10. Total parenteral nutrition services;
11. Chemotherapy; and
12. Hospice.

B. The following shall be excluded as Title XXI covered services:
1. Abortion counseling,
2. Services or items furnished solely for cosmetic purposes,
3. Chiropractic services, and
4. Licensed midwife service for prenatal care and home births.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-216. Nursing Facility Services

A. Nursing facility services including room and board shall be covered for a maximum of 90 days per contract year if the medical condition of a member is such that, if nursing facility services are not provided, hospitalization of the individual would result.

B. Except as otherwise provided in 9 A.A.C. 28, the following services shall be excluded for purpose of separate billing if provided in a nursing facility:
1. Nursing services including but not limited to:
   a. Administration of medication,
   b. Tube feedings,
   c. Personal care services (assistance with bathing and grooming),
   d. Routine testing of vital signs, and
   e. Maintenance of catheters.
2. Basic patient care equipment and sickroom supplies, including, but not limited to:
   a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over the counter remedies;
   b. Bathing and grooming supplies;
   c. Identification devices;
   d. Skin lotions;
   e. Medication cups;
   f. Alcohol wipes, cotton balls, and cotton rolls;
   g. Rubber gloves (non sterile);
   h. Laxatives;
   i. Beds and accessories;
   j. Thermometers;
   k. Ice bags;
   l. Rubber sheeting;
   m. Passive restraints;
   n. Glycerin swabs;
   o. Facial tissue;
   p. Enemas;
   q. Heating pads; and
   r. Diapers.
3. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating;
4. Any services that are included in a nursing facility's room and board charge or services that are required of the nursing facility to meet federal mandates, state licensure standards, or county certification requirements;
5. Administrative physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
6. Physical therapy; and
7. Assistive devices and durable medical equipment.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-31-301. General Requirements

A. Administration. The Administration shall administer the program as specified in A.R.S. § 36-2982.

B. Operational authority. The Director has full operational authority to adopt rules or to use the appropriate rules for the development and management of an eligibility and enrollment system as specified in A.R.S. § 36-2986.

C. Expenditure limit and enrollment.
1. Title XXI will accept enrollees subject to the availability of funds. If the Director determines that monies may be insufficient for the program, the Administration shall stop processing applications for the program as specified in A.R.S. § 36-2985.
2. After the Administration has verified that funding is sufficient, it will resume processing applications as specified in A.R.S. § 36-2985.
3. The Administration shall immediately stop processing all applications and shall provide 30 days advance notice to a member that the program will terminate on the 1st day of the following month after notice is served, if the federal government:
   a. Eliminates federal funding for the program, or
   b. Significantly reduces the federal funding below the estimated federal expenditures according to A.R.S. § 36-2985.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-302. Applications

A. Availability. The Administration shall make available Title XXI applications. Any person may request a Title XXI application.

B. Submission of Applications. An application shall be completed and submitted to the Administration:
1. In person,
2. By mail,
3. By fax, or
4. By other form approved by the Administration.

C. Date of application. The date of application is the date the Administration receives an application which:
1. Is signed by a person making an application,
2. Includes the name of the person for whom assistance is requested, and
3. Includes the address and telephone number of the person submitting the application.

D. Completed application.
1. The Administration shall consider an application complete when:
   a. All questions are answered,

b. An enrollment choice is included, and
c. All necessary verification is provided by an applicant or an applicant's representative.

2. When the application is incomplete, the Administration shall:
a. Contact an applicant or an applicant's representative by telephone to obtain the missing information required for an eligibility determination; or
b. Mail a pending notice to an applicant or an applicant's representative, allowing 10 days from the date of the notice to provide the required information listed on the pending notice.

E. Eligibility determination processing time.
1. Except when there is an emergency beyond the Administration's control, the Administration shall not delay the eligibility determination beyond 30 days from the date of application when information and verification necessary to make the determination has been provided and obtained.
2. An applicant shall provide the Administration with all requested verification within 10 days from the notice date of the written request for the information. If an applicant fails to provide the requested information and fails to request an extension of the 10 day period, the Administration may deny eligibility.

F. Waiting list. If the Administration stops processing an application because the monies are insufficient as specified in R9-31-301(C)(1), the Administration shall place an applicant on a waiting list and notify the applicant. When increased funding becomes available, the Administration shall contact an applicant on the waiting list and ask the applicant to submit a new application if the original application is more than 60 days old. Spaces will be filled as a completed application is received and approved.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-303. Eligibility Criteria
Eligibility. To be eligible for the program, a person shall meet all the following eligibility requirements:

A. Age. Is under 19 years of age. A child's coverage will continue through the month in which a child turns age 19 if the child is otherwise eligible;
B. Citizenship. Is a United States citizen or a qualified alien as specified in A.R.S. § 36-2983;
C. Residency. Is a resident of the state of Arizona as specified in A.R.S. § 36-2983. An Arizona resident is a person who currently lives in Arizona and intends to remain in Arizona indefinitely;
D. Income. Meets the income requirements in R9-31-304;
E. Cost sharing. Pays the cost sharing premium amount when premiums are required as specified in A.R.S. § 36-2982;
F. Social security number. Provides a social security number or applies for one within 30 days after an applicant submits a Title XXI application as specified in A.R.S. § 36-2983. The Administration shall not deny eligibility for Title XXI if an applicant does not provide or apply for a social security number unless the sole reason the child is ineligible for Title XIX is for failure to comply with social security number requirements specified in 42 CFR 435.910 and 42 CFR 435.920 as of May 29, 1986, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments;
G. Assignment. Assigns rights to any 1st- or 3rd-party coverage of medical care as specified in 9 A.A.C. 31, Article 10;
H. Other federal program. Is not eligible for Title XIX or other federally operated or financed health care insurance program, except the Indian Health Service or a Tribal Facility as specified in A.R.S. § 36-2983;
I. Inmate of a public institution. Is not an inmate of a public institution, as specified in A.R.S. § 36-2983;
J. Patient in an institution for mental disease. Is not a patient in an institution for mental disease at the time of application, or at the time of redetermination, as specified in A.R.S. § 36-2983;
K. Other health coverage. Is not covered under:
1. An employer's group health insurance plan,
2. Family or individual health insurance, or
3. Other health insurance;

L. State health benefits. Is not a member of a family that is eligible for health benefits coverage under a state health benefit plan based on an applicant, a member, or a parent's employment with a public agency in the state of Arizona;
M. Prior health insurance coverage. Has not been covered by health insurance during the previous 6 months unless that health insurance was discontinued due to the involuntary loss of employment as specified in A.R.S. § 36-2983. The 6 months of ineligibility due to previous insurance coverage shall not apply to:
1. A newborn as defined in R9-31-309;
2. A Title XIX member as specified in 9 A.A.C. 22, Article 1;
3. An MI/MN member as specified in 9 A.A.C. 22, Article 1;
4. An EAC member as specified in 9 A.A.C. 22, Article 1;
5. An ELIC member as specified in 9 A.A.C. 22, Article 1;
6. A state funded SSI-MAO non-qualified alien as specified in A.R.S. § 36-2903.03;
7. A Title XXI member;
8. A CRS member; or
9. A Native American member receiving services from IHS or a Tribal Facility.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-304. Income Eligibility

A. Income standard. The combined gross income of the household income group members as specified in subsection (C) shall not exceed the percentage of the appropriate FPL for the Title XXI household income group size as specified in A.R.S. § 36-2981 for the state fiscal year.
B. Countable income. The Administration shall count all income received during a month by the household income group members as specified in subsection (C) except income which is specified in subsections (D) and (E).
C. Title XXI household income group.
1. For this Section:
a. "Child" means a person under 19 years of age or an unborn child.
b. "Parent" means a biological, adoptive or step parent.
2. The following related persons, when residing together, constitute a Title XXI household income group:
a. A married couple and children of either 1 or both;
b. An unmarried couple with a common child and other children of either 1 or both;
c. A married couple when 1 or both are under age 19 with no children;

d. A single parent and the single parent's children;
e. A child who does not live with a parent; and
f. The following persons, when living with a child:
i. A spouse of the child;
ii. A child of the spouse child;
iii. A child of the child; and
iv. The other parent of a child of the child.

3. A person who is absent from a household shall be included in the child's household income group if absent:
a. For 30 days or less,
b. For the purpose of seeking employment or to maintain a job,
c. For serving in the military,
d. For an educational purpose and the child's parent claims the child as a dependent on the parent's income tax return.

D. Income disregards. When determining gross income of the household, the Administration shall disregard the following:
1. Income specified in 20 CFR Part 416 Appendix K as of April 1, 1997, which is incorporated by reference and on file with the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments;
2. Income paid according to federal law that prohibits the use of the income when determining eligibility for public benefits;
3. Money received by a member as the result of the conversion of an asset;
4. Income tax refunds; and
5. For a self-employed household member, the Administration shall count only the net income of that self-employment, after deducting the expenses of producing that income, but not income taxes or capital investments.

E. Regular infrequent income. Income that is received regularly but less often than monthly shall be pro-rated over the number of months between payments with only the pro-rated monthly amount.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-305. Verification
Verification. An applicant or a member shall provide the Administration with verification or authorize the release of verification to the Administration of all information necessary to complete the determination of eligibility.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-306. Enrollment

A. Selection choices.
1. Except as provided in subsections (A)(3), (4), and (5), at the time of application, an applicant shall select from the following enrollment choices:
a. A contractor which includes a health plan or a qualifying plan as defined in A.R.S. § 36-2981,
b. A qualifying health center as specified in A.R.S. § 36-2907.06, or
c. The IHS as specified in A.R.S. § 36-2982. If a member is enrolled with the IHS, a member may elect to receive covered services from a participating 638 tribal facility.
2. Except as provided in subsections (A)(3), (4), and (5), coverage shall not begin until a Title XXI enrollment choice is made.
3. The Administration shall enroll a member with CMDP when a member is a foster care child according to A.R.S. § 8-512.
4. When a Title XIX member becomes ineligible for Title XIX and DES determines a child eligible for Title XXI with no break in coverage,
a. The Title XXI child shall remain enrolled with the Title XIX contractor; and
b. The Administration shall send the Title XXI member a notice explaining the member's right to choose as specified in subsection (A)(1).
5. When a person applies for Title XIX through DES and DES determines a child ineligible for Title XIX but eligible for Title XXI, the Administration shall enroll the child for Title XXI as follows:
a. If a Title XIX health plan pre-enrollment choice is pending at the time the Administration receives the Title XXI approval from DES, the Administration may:
i. Enroll a child with the Title XIX health plan, and
ii. Notify the member of the member's enrollment and provide the member an opportunity to select an enrollment choice as specified in subsection (A)(1).
b. If there is no pending Title XIX choice at the time the Administration receives the Title XXI approval from DES, the Administration shall pend the Title XXI decision and obtain a choice from the member as specified in subsection (A)(1).

B. Effective date of initial enrollment.
1. For eligibility determinations completed by the 25th day of the month, enrollment shall begin on the 1st day of the month following the determination of eligibility.
2. For eligibility determination completed after the 25th day of the month, enrollment shall begin on the 1st day of the 2nd month following the determination of eligibility.

C. Enrollment changes.
1. If a member moves from 1 GSA to another GSA during the period of enrollment, enrollment changes will occur as follows:
a. If a member's current enrollment choice is available in a member's new GSA, a member will remain enrolled with the member's current enrollment choice.
b. If a member's current enrollment choice is not available in the new GSA, a member shall:
i. Remain enrolled with the current enrollment choice. The current enrollment choice may limit services to emergency services outside the GSA as specified in R9-31-201.
ii. Select from the enrollment choices provided in R9-31-306(A)(1) that are available in the new GSA. Once a new choice is made, a member shall be enrolled with the new choice effective with the date the Administration processes a member's enrollment choice. Covered services shall be available on the date of the enrollment change.
2. A member may change a member's enrollment choice:
a. During a member's annual enrollment choice period,
b. At any time from:

i. IHS to a contractor as specified in subsection (A)(1) of this Section;
ii. A contractor to IHS,
iii. IHS to a qualifying health center as specified in subsection (A)(1) of this Section,
iv. A qualifying health center to IHS,
v. A qualifying health center to a contractor.

c. When a member is no longer a foster care child as specified in subsection (A)(3) of this Section.

3. Except for subsection (C)(2)(c) of this Section, the effective date of the new enrollment choice is the date the Administration processes the enrollment choice. The effective date of the enrollment change from CMDP to a Title XXI choice as specified in subsection (A)(1) of this Section, shall be the 1st of the following month.

E. Annual enrollment choice period. A member shall have the opportunity to change enrollment within at least 12 months from the date of initial enrollment and then 12 months following the last time a member made an enrollment choice or had the opportunity to make an enrollment choice.

F. Health Insurance Portability and Accountability Act of 1996. As specified in A.R.S. § 36-2982, a Title XXI member who has been disenrolled shall be allowed to use enrollment in the Title XXI program as creditable coverage as defined in A.R.S. § 36-2984.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-307. Guaranteed Enrollment

A. Guaranteed Enrollment. A child who has been determined eligible for Title XXI will be guaranteed a 1 time 12 month period of continuous coverage unless a child:

1. Attains age 19,
2. Is no longer a resident of the state,
3. Is an inmate of a public institution,
4. Is enrolled with Title XIX,
5. Is determined to have been ineligible at the time of approval,
6. Obtains private or group health coverage,
7. Is adopted and the new household does not meet the qualifications of this program,
8. Does not pay cost sharing premium amount when premiums are required as specified in A.R.S. § 36-2982,
9. Is a patient in an institution for mental diseases,
10. Voluntarily withdraws from the program, or
11. Whereabouts is unknown.

B. The 12 month guaranteed period will begin with the month an applicant is initially enrolled.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-308. Changes and Redeterminations

A. Reporting Changes. A member or a member's parent or guardian shall report the following changes to the Administration:

1. Any change in income that will begin or continue into the following month,
2. Any change of address,
3. The addition or departure of a household member,
4. Any health coverage under private or group health insurance,
5. Employment of a member or a parent with a state agency, and
6. Incarceration of a member.

B. Verification. If required verification is needed and requested as a result of a change specified in subsection (A) of this Section to determine the impact on eligibility and is not received within 10 days, the Administration may discontinue eligibility for a member unless a member is within the guaranteed eligibility period as specified in R9-31-307.

C. Redeterminations. If no change is reported, the Administration shall initiate redetermination no later than the end of the 12th month after the effective date of eligibility, or the completion of the most recent redetermination application, whichever is later.

D. Termination. If the Administration determines that a child no longer meets the eligibility criteria, or a child, a parent, or a guardian fails to respond or cooperate with the redetermination of eligibility, coverage will be terminated.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-309. Newborn Eligibility

A. Eligibility. A child born to a Title XXI member, is eligible for 12 months of coverage without filing an application under Title XXI provided:

1. The child continues to live with its mother during the 12 month period; and
2. One of the events as specified in R9-31-307(A) does not occur.

B. Deemed Coverage. A newborn's deemed newborn coverage shall begin effective with a newborn's date of birth and end with the last day of the month in which a newborn turns age 1. Deemed newborn status does not preclude a child from applying for Title XIX and being approved.

C. Enrollment choice for a newborn. A newborn shall be enrolled with a mother's enrollment choice as specified in contract.

D. Notification of enrollment. The Administration shall notify a mother of a newborn's enrollment and provide a mother an opportunity to select an enrollment choice as specified in R9-31-306(A)(1).

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-310. Notice Requirements

A. Applications. Upon completion of a determination of eligibility or ineligibility for any child in the household, the Administration shall issue a written notice to an individual who initiated the application. This notice shall include a statement of the intended action, an explanation of a person's hearing rights as specified in 9 A.A.C. 31, Article 8 and:

1. If approved, the notice shall contain the name and effective date of eligibility for each approved applicant;
2. If denied, the notice shall contain:
   a. The name of each ineligible applicant,
   b. The effective date of the denial,
   c. The reasons for ineligibility including appropriate income calculations and income standard when the reason for the denial is based on excess income,
   d. The legal authority supporting the reason for ineligibility, and
   e. Where the references are physically located for review.

B. Terminations.

1. When the Administration proposes a termination of Title XXI eligibility, the Administration shall provide a member with:
   a. Advance notice at least 10 days before the effective date of the adverse action except as provided in subsection (B)(1)(b); or
   b. Adequate notice no later than the date of adverse action when a member:
      i. Voluntarily withdraws and indicates an understanding of the results of the action,
      ii. Becomes an inmate of a public institution as specified in R9-31-303(I),
      iii. Dies and the Administration has verification of the death,
      iv. Has whereabouts that are unknown and the Administration's loss of contact is confirmed by returned mail from the post office with no forwarding address, or
      v. Is approved for Title XIX.
2. In addition to the requirements listed in subsection (A)(2), the termination notice shall include an explanation of a member's right to continued Title XXI coverage pending appeal as provided in 9 A.A.C. 31, Article 8.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

ARTICLE 4. CONTRACTS

R9-31-401. General Provisions

A. Administration and contract authority. The Administration shall administer the program as specified in A.R.S. § 36 -2982.

B. Rule authority. The Director has full operational authority to use the appropriate rules adopted for contract administration and oversight of contractors as specified in A.R.S. § 36-2986.

C. For purposes of this Chapter, as specified in A.R.S. § 36-2981, contractor includes the following:
1. A health plan as specified in A.R.S. § 36-2981; or
2. A qualifying plan as specified in A.R.S. § 36-2981 and that provides services to members as specified in A.R.S. § 36-2989.

D. Exemption from procurement process. The Administration is exempt from the procurement code as specified in A.R.S. §§ 36-2988 and 41-2501.

E. Contractor's financial responsibility. The Administration shall specify in contract when a person who has been determined eligible will be enrolled with a contractor and the date on which the contractor will be financially responsible for health and medical services to the person as specified in A.R.S. § 36-2987.

F. Contract. A contract may be canceled or rejected in whole or in part as specified in contract if it is deemed by the Director to be in the best interest of the state. The reasons for cancellation or rejection shall be made part of the contract file.

G. Damages or claims. Offerors shall have no right to damages or basis for any claims against the state, its employees, or agents, arising out of any action by the Administration according to the provisions of subsection (F).

H. Ownership interest. A contractor shall not knowingly have a director, officer, partner, or person with ownership of more than 5% of the contractor's equity who has been debarred or suspended by any federal agency, as specified in 42 U.S.C. 1396u-2, as of August 5, 1997, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future additions or amendments.

I. Certification. The Administration shall certify a contractor as a risk-bearing entity as specified in 42 U.S.C. 1396b(m), as of August 5, 1997, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future additions or amendments.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-402. Administration's Contracts with Contractors

A. Contracts with the Administration. The Administration shall use contractors that have a contract with the Administration to provide services to members who qualify for the program as specified in A.R.S. § 36-2988.

B. Conditions when the Administration is a contractor. The Director may require contract terms allowing the Administration to operate a contractor directly under circumstances specified in the contract according to A.R.S. § 36-2986.

C. Expansion or contraction of services or services areas. The Director may negotiate with any successful bidder for the expansion or contraction of services or service areas, after contracts have been awarded as specified in A.R.S. § 36-2988.

D. Amending contracts. The Administration has full authority to amend existing contracts awarded in compliance with A.R.S. § 36-2988.

E. Content of contract. Each contract between the Administration and a contractor shall be in writing and contain at least the following information:
1. The method and amount of compensation or other consideration to be received by the contractor.
2. The name and address of the contractor.
3. The population to be covered by the contractor.
4. The amount, duration, and scope of medical services to be provided, or for which compensation will be paid for Title XXI coverage.
5. The term of the contract, including the beginning and ending dates, as well as methods of extension, renegotiation, and termination.
6. A provision that the Director may evaluate, through inspection or other means, the quality, appropriateness, or timeliness of services performed under the contract.
7. A description of the eligibility requirements for a Title XXI member, medical and cost record-keeping systems, and a provision that the Director may audit and inspect any of the contractor's records that pertain to services performed and determinations of amounts payable under the contract. These records shall be maintained by the contractor for 5 years from the date of final payment or, for records relating to costs and the date of final payment or, for records relating to costs and expenses to which the Administration has taken exception, 5 years after the date of final disposition or resolution of the exception.
8. A provision that contractors maintain all forms, records, and statistical information required by the Director for purposes of audit and program management. This material, including files, correspondence, and related information pertaining to services rendered or claims for payments shall be subject to inspection and copying by the Administration or by the Department of Health and Human Services during normal business hours at the place of business of the person or organization maintaining the records.
9. A provision that the contractor safeguard information.

10. Any activities to be performed by the contractor affecting members that are related to 3rd-party liability requirements prescribed in A.R.S. § 36-2986.
11. Functions that may be subcontracted, including a provision that any subcontract meets the requirements of 42 CFR 434.6, as of December 30, 1983, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
12. A provision that the contractor arrange for the collection of any required copayment by the provider.
13. A provision that the contractor will not bill or attempt to collect from a Title XXI member for any covered service except as authorized by statute or these rules.
14. A provision that the contract will not be assigned or transferred without the prior approval of the Director.
15. Procedures for enrollment or re-enrollment of a covered population.
16. Procedures and criteria for terminating the contract.
17. A provision that any cost sharing requirements imposed for services furnished to members are in accordance with A.R.S. § 36-2982, and 42 CFR 447.50 through 447.58, as of December 19, 1990, which are incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
18. Procedures for terminating enrollment and choice of health professional.
19. A provision that specifies the rates are actuarially sound.
20. A provision that a contractor provide for an internal grievance procedure that:
    a. Is approved in writing by the Administration;
    b. Provides for prompt resolution; and
    c. Ensures the participation of individuals with authority to require corrective action.
21. A provision that the contractor maintain an internal quality management system consistent with A.R.S. § 36-2986 and Title XXI rule and policy as specified in R9-31-522.
22. A provision that the contractor submit marketing plans, procedures, and materials to the Administration for approval before implementation.
23. A statement that all representations made by contractors, or authorized representatives are truthful and complete to the best of their knowledge.
24. A provision that the contractor is responsible for all:
    a. Tax obligations;
    b. Worker's Compensation Insurance; and
    c. All other applicable insurance coverage, for itself and its employees, and that the Administration has no responsibility or liability for any of the taxes or insurance coverage.
25. A provision that the contractor agrees to comply with all applicable statutes and rules.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-403. Subcontracts

A. Approval. A contractor entering into a subcontract to provide services to a Title XXI member must meet the requirements specified in the contract. Any amendment to a subcontract shall be subject to review and approval by the Director. No subcontract alters the legal responsibility of a contractor to the Administration to ensure that all activities under the contract are carried out.

B. Subcontracts. Each subcontract shall be in writing and include a:
1. Provision that the subcontract is to be governed by, and construed in accordance with all laws, rules, and contractual obligations of the contractor.
2. Provision to notify the Administration in the event the subcontract is amended or terminated.
3. Provision that assignment or delegation of the subcontract is voidable, unless prior written approval is obtained from the Administration.
4. Provision to hold harmless the state, the Director, the Administration, and a Title XXI member in the event the contractor cannot or will not pay for covered services performed by the subcontractor.
5. Provision that the subcontract and subcontract amendments are subject to review and approval by the Director as established in these rules and that a subcontract or subcontract amendment may be terminated, rescinded, or canceled by the Director for a violation of these rules.
6. Provision to hold harmless and indemnify the state, the Director, the Administration, or a Title XXI member against claims, liabilities, judgments, costs and expenses with respect to third parties, which may accrue against the state, the Director, the Administration, or a Title XXI member, through the negligence of the subcontractor.
7. Provision that a Title XXI member is not to be held liable for payment to a provider in the event of contractor's bankruptcy; and
8. Provision that the requirements contained in R9-31-402(E)(1) through (E)(10) and (E) (13), (14), (16), (20), (23), (24), (25) apply but substitute the term "subcontractor" wherever the term "contractor" is used.

C. Waiver. A contractor may submit a written request to the Administration requesting a waiver of the requirement that the contractor subcontract with a hospital in the contractor's service area. The request shall state the reasons a waiver is believed to be necessary and shall state all efforts the contractor has made to secure a subcontract. For good cause shown, the Administration may waive the hospital subcontract requirement. The Administration shall consider the following criteria in deciding whether to waive the hospital subcontract requirement:
1. The number of hospitals in the service area.
2. The extent to which the contractor's primary care physicians have staff privileges at noncontracting hospitals in the service area.
3. The size and population of, and the demographic distribution within, the service area.
4. Patterns of medical practice and care within the service area.
5. Whether the contractor has diligently attempted to negotiate a hospital subcontract in the service area.
6. Whether the contractor has any subcontracts in adjoining service areas with hospitals that are reasonably accessible to the contractor's members in the service area.
7. Whether the contractor's members can reasonably be expected to receive all covered services in the absence of a hospital subcontract.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-404. Contract Amendments; Mergers; Reorganizations

Any merger, reorganization, or change in ownership of a contractor shall require that the contractor submit the contract between the Administration and the contractor for amendment and prior approval by the Director. Additionally, any merger, reorganization, or change in ownership of a subcontractor that is related to or affiliated with the contractor shall constitute a contract amendment which requires the prior approval of the Director. To be effective, contract amendments shall be in writing and executed by the Director.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-405. Suspension, Denial, Modification, or Termination of Contract

A. General. The Director may suspend, deny, refuse or fail to renew, or terminate a contract or subcontract for good cause as specified in contract.

B. Modification and termination of the contract without cause. The Administration and contractor by mutual consent may modify or terminate the contract at any time without cause. Additionally, the Administration may terminate or suspend the contract in whole or in part without cause effective 30 days after mailing written notice of termination or suspension by certified mail, return receipt requested to the contractor.

C. Notification.

1. The Director shall provide the contractor written notice of intent to:
   a. Suspend;
   b. Deny;
   c. Fail to renew; or
   d. Terminate a contract or related subcontract.
2. The Administration shall provide a notice to an affected principal, an enrolled member and an other interested party, and shall include:
   a. The effective date; and
   b. Reason for the action.
3. The Administration shall immediately stop processing all applications and shall provide 30 days advance notice to a contractor that the program will terminate on the 1st day of the following month after notice is served, if the federal government:
   a. Eliminates federal funding for the program; or
   b. Significantly reduces the federal funding below the estimated federal expenditures according to A.R.S. § 36-2985.

D. Records.

1. All medical, financial, and other records shall be retained by a terminated contractor in accordance with state laws and rules. Medical records or copies of medical records may be required to be submitted to the Director, or designee, within 10 working days of the effective date of contract termination.
2. All contract records shall be retained for a period of 5 years and disposed of as specified in A.R.S. § 36-2986.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-406. Contract: Sanction; Performance; and Solvency

A. The Director may impose a sanction upon a contractor that violates any provision of the rules as specified in contract.

B. Adequate performance. The Director shall require contract terms that are necessary to ensure adequate performance by the contractor as specified in A.R.S. § 36-2986 and 9 A.A.C. 31, Article 5.

C. Solvency. The Director shall establish solvency requirements in contract as specified in A.R.S. § 36-2986 and 9 A.A.C. 31, Article 5.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-407. Contract or Protest, Appeal

The contractor shall file a grievance as specified in A.A.C. R9-22-804.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-31-501. General Provisions

A. As specified in A.R.S. § 36-2986, the Director has full operational authority to adopt rules or to use the appropriate rules adopted for this Article.

B. Pre-existing Conditions. Eligibility for the program may not be denied based on a child having a pre-existing medical condition as specified in 42 U.S.C. 1397, August 5, 1997, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

1. Except as otherwise provided in Article 3 of this Chapter, a contractor shall be responsible for providing the full scope of covered services to each member from the effective date of eligibility until the time of notification of termination, suspension, or transfer of the member's enrollment. This responsibility includes providing treatment for all of a member's pre-existing conditions.
2. A contractor or subcontractor shall not adopt or use any procedure to identify individuals who have an existing or anticipated medical or psychiatric condition in order to discourage or exclude the individuals from enrolling in the contractor's health plan or encourage the individuals to enroll in another health plan.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-502. Availability and Accessibility of Service

A. A contractor shall provide adequate numbers of available and accessible:

1. Institutional facilities;
2. Service locations;
3. Service sites; and
4. Professional, allied, and paramedical personnel for the provision of covered services, including all emergency medical services for 24 hours a day, 7 days a week.

B. A contractor shall minimally provide the following:

1. A ratio of primary care providers to members, as specified in contract;
2. A designated emergency services facility, providing care 24 hours a day, 7 days a week, accessible to members in each contracted service area. One or more physicians and 1 or more nurses shall be on call or on duty at the facility at all times;

3. An emergency services system employing at least 1 physician, registered nurse, physician's assistant, or nurse practitioner, accessible by telephone 24 hours a day, 7 days a week, to members who need information in an emergency, and to providers who need verification of patient membership and treatment authorization;
4. An emergency services call log or database to track the following information:
   a. Member's name,
   b. Address and telephone number,
   c. Date and time of call,
   d. Nature of complaint or problem, and
   e. Instructions given to member.
5. A written procedure for communicating emergency services information to a member's primary care provider, and other appropriate organizational units;
6. An appointment standard as specified in contract for the following:
   a. Emergency appointments,
   b. Urgent care appointments, and
   c. Routine care appointments.
7. Waiting times for members with appointments that do not exceed 45 minutes, except when the provider is unavailable due to an emergency.

C. A contractor shall have an affiliation with or subcontract with an organization or individual to provide primary care services. The contractor shall agree to provide services under the primary care provider's guidance and direction.
1. A primary care provider selected by or to whom an enrolled member is assigned shall be responsible for:
   a. Supervising, coordinating, and providing initial and primary care to the member;
   b. Initiating referrals for specialty care;
   c. Maintaining continuity of member care; and
   d. Maintaining an individual medical record for each assigned member.
2. A primary care provider or specialist providing inpatient services to a member shall have staff privileges in a minimum of 1 general acute care hospital under subcontract with the contractor, within the service area of the contractor.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-503. Reinsurance

A. Contractor-acquired reinsurance. As specified in A.R.S. § 36-2988, a contractor may obtain reinsurance for coverage of prepaid capitated members. A contractor shall not obtain reinsurance to reduce liability below 25% of the applicable deductible level during any Title XXI contract year. This limitation does not apply to reinsurance obtained by a contractor to cover the cost of services provided by noncontracting providers and nonproviders to a member under emergency circumstances.

B. Administration reinsurance. For purposes of the Administration's reinsurance program, the insured entity shall be a prepaid plan with which the Administration contracts. Only costs incurred during the contract year in which a member is enrolled with a contractor qualify for reinsurance. Any movement of a member from membership with 1 contractor to membership with another contractor shall be cause for resetting the deductible level unless resetting is waived by the Administration.

C. Encounter submission. A contractor shall prepare, review, verify, certify, and submit, encounters for consideration to the Administration.
1. The contractor shall certify that the services listed were actually rendered, medically necessary, and within the scope of Title XXI benefits.
2. The contractor shall submit encounters in the format prescribed by the Administration.
3. The contractor shall initiate and evaluate an encounter for probable 1st-and 3rd-party liability before submitting the encounter for reinsurance consideration to the Administration, unless the encounter involves underinsured or uninsured motorist liability insurance, 1st- and 3rd-party liability insurance, or a tort-feasor.
4. The Administration shall not consider a reinsurance claim for payment unless the claim is received by the AHCCCS Claims Administration not later than 9 months from the close of the contract year in which the claim is incurred or 9 months after the date of eligibility posting, whichever is later. If a claim meets the 9-month limitation, the contractor shall file a clean claim which is received by the AHCCCS Claims Administration not later than 12 months from the close of the contract year in which the claim is incurred or 12 months after the date of eligibility posting, whichever is later. The 9 month deadline for an inpatient hospital claim begins on the date of discharge for each claim.

D. Encounter processing. The Administration shall process reinsurance associated or related encounters submitted by a contractor.
1. The Administration shall accept for processing only those encounters that are submitted directly by a Title XXI contractor and that comply with the conditions in subsections (B), (C), (E), and (F).
2. The Administration shall establish and maintain separate records of all reinsurance cases established and all payments and case reviews made to the contractor as a result of these cases.
3. The Administration shall subject a contractor to utilization of services and other evaluative reviews of care provided to a member that result in a reinsurance case.

E. Payment of reinsurance cases. The Administration shall reimburse a contractor for costs incurred in excess of the applicable deductible level calculated according to the provisions of A.A.C. R9-22-703.

F. The Administration may limit reinsurance reimbursement to a lower or alternative level of care if the Director or designee determines that the less costly alternative could and should have been used by the contractor. A contractor whose reinsurance case is reduced or denied shall be notified in writing by the Administration. The notification shall include the cause for reduction or denial and describe the applicable grievance and appeal process available under 9 A.A.C. 31, Article 8.

G. The Administration or its contractors may arrange special contractual reinsurance terms for catastrophic cases. Catastrophic cases include, but are not limited to organ and bone marrow transplants (excluding kidney and cornea transplants which are covered under regular reinsurance), and hemophiliac cases. The contractor shall notify the Administration when a member is identified for possible reimbursement of Title XXI-approved catastrophic cases. The determination of whether a case or type of case is catastrophic shall be made by the Director based on the following criteria:
1. Severity of medical condition, including prognosis; and

2. Average cost or average length of hospitalization and medical care, or both, in Arizona for the type of case under consideration.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-504. Marketing; Prohibition against Inducements; Misrepresentations; Discrimination; Sanctions

A. A contractor or the contractor's marketing representative shall not offer or give any form of compensation or reward, or engage in any behavior or activity that may be reasonably construed as coercive, to induce or procure Title XXI enrollment. A contractor may make Title XXI applications available, but shall not assist with the completion of an application or steer an applicant into a particular contractor. Any marketing solicitation offering a benefit, good, or service, in excess of the covered services in 9 A.A.C. 31, Article 2 shall be deemed an inducement.

B. A marketing representative shall not misrepresent itself, the contractor represented, or the Title XXI program, through false advertising, false statements, or in any other manner to induce a member of another contracting entity to enroll in the represented contractor.

1. The Administration shall deem violations of this subsection to include, but not be limited to, false or misleading claims, inferences, or representations that:
   a. A member will lose benefits under the Title XXI program or any other health or welfare benefits to which the member is legally entitled, if the member does not enroll in the represented contractor;
   b. Marketing representatives are employees of the state or representatives of the Administration, a county, or any contractor other than the contractor with whom they are employed, or by whom they are reimbursed; and
   c. The represented contractor is recommended or endorsed as superior to its competition by any state or county agency, or any organization, unless the organization has certified its endorsement in writing to the health plan and the Administration.

C. A marketing representative shall not engage in any marketing or pre-enrollment practice that discriminates against a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.

D. The Administration shall hold a contractor responsible for the performance of any marketing representative, subcontractor or agent, program, or process under its employ or direction and shall make the contractor subject to the contract sanctions in this Chapter.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-505. Approval of Advertisements and Marketing Materials

A. A contractor shall submit its proposed advertisements, marketing materials, and paraphernalia for review and approval by the Administration before distributing the materials or implementing the activities.

B. A contractor shall submit all proposed marketing materials in writing to the Administration.

C. The Administration shall review and approve or disapprove all marketing materials. The Administration shall include a statement of objections and recommendations in a notice of disapproval.

D. To minimize the expense of revising advertising or other copy, a contractor may submit the marketing materials in draft form, subject to final approval and filing of a proof or final copy.

E. A contractor shall provide 2 copies of the proof or final approved copy of marketing materials to the Administration.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-506. Reserved

R9-31-507. Member Record

As specified in A.R.S. § 36-2986, a contractor shall maintain a member service record that contains at least the following for each member:

1. Encounter data,
2. Grievances and appeals,
3. Any informal complaints, and
4. Service information.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-508. Limitation of Benefit Coverage for Illness or Injury due to Catastrophe

The Director may limit the scope of health care benefits provided by a prepaid capitated contractor to exclude the care of illness or injury that results from, or is greatly aggravated by, a catastrophic occurrence, including an act of declared or undeclared war, that occurs after enrollment.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-509. Transition and Coordination of Member Care

A. As specified in A.R.S. § 36-2986, the Administration shall coordinate and implement disenrollment and re-enrollment procedures when a member's change of residency requires a change in contractor.

B. A contractor shall assist in the transition of members to and from other contractors.

1. Both the receiving and relinquishing contractor shall:
   a. Coordinate with the other contractor to facilitate and schedule appointments for medically necessary services for the transitioned member within the Administration's timelines specified in the contract. A contractor's policies and procedures regarding transition of members are subject to review and approval by the Administration;
   b. Assist in the referral of transitioned members to other community health agencies or county medical assistance programs for medically necessary services not covered by the Administration, as appropriate; and
   c. Develop policies and procedures to be followed when transitioning members who have significant medical conditions, are receiving ongoing services, or have, at the time of the transition, received prior authorization or approval for undelivered, specific services.

2. The relinquishing contractor shall notify the receiving contractor of relevant information about the member's medical condition and current treatment regimens within the timelines defined in contract;
3. The relinquishing contractor shall forward medical records and other materials to the receiving contractor. The cost of reproducing and forwarding medical records and other materials shall be borne by the relinquishing contractor;
4. Within the contract-specified timelines, the receiving contractor shall ensure that the member selects or is assigned to a primary care provider, and provide the member with:
   a. Information regarding the contractor's providers,
   b. Emergency numbers, and
   c. Instructions about how to obtain new services.

C. A contractor shall not use a county or nonprovider health resource alternative that diminishes the contractor's contractual responsibility or accountability for providing the full scope of covered services. Referrals made to other health agencies by a contractor, primarily to reduce expenditures incurred by the contractor on behalf of its members, may result in the application of sanctions described in this Chapter.

D. A contractor may transfer a member as specified in A.R.S. § 36-2986, from a noncontracting provider to a contracting provider's facility as soon as a transfer will not be harmful to the member's health as authorized by the member's primary care provider or the contractor's Medical Director. A member's plan shall pay the cost of transfer.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-510. Transfer of Members

As specified in A.R.S. § 36-2989, a contractor shall implement procedures to allow a member to transfer from the primary care provider of record to another primary care provider within the same contracting organization. Criteria for a transfer include, but are not be limited to:

1. Change in the member's health, requiring a different medical focus;
2. Change in the member's residency resulting in difficulty in obtaining services from the assigned primary care provider; or
3. Identification of any problem between the member and the primary care provider, resulting in deterioration of the primary care provider - member relationship.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-511. Fraud or Abuse

As specified in A.R.S. §§ 36-2986 and 36-2992, a contractor, provider, or nonprovider shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-512. Release of Safeguarded Information by the Administration and Contractors

A. The Administration, a contractor, a provider, and a noncontracting provider shall safeguard information concerning an applicant or member which includes the following:
1. Name and address;
2. Social Security number;
3. Social and economic conditions or circumstances;
4. Agency evaluation of personal information;
5. Medical data and services, including diagnosis and history of disease or disability;
6. State Data Exchange (SDX) tapes from the U.S. Social Security Administration; and
7. Information system tapes from the Arizona Department of Economic Security.

B. The restriction upon disclosure of information does not apply to:
1. Summary data,
2. Statistics,
3. Utilization data, and
4. Other information that does not uniquely identify an applicant or member.

C. The Administration, a contractor, a provider, and a noncontracting provider shall use or disclose information concerning an applicant or member only under the conditions specified in subsection (D), (E), and (F) and only to:
1. The person concerned,
2. Individuals authorized by the person concerned, and
3. Persons or agencies for official purposes.

D. Safeguarded information shall be viewed by or released for only:
1. An applicant;
2. A member; or
3. An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:
   a. An Administration employee or its authorized representative, or responsible caseworker is present during the examination of the eligibility record; or
   b. As outlined in subsection (E) after written notification to the provider, and at a reasonable time and place.
4. A purpose as specified in R9-31-512(F).

E. An eligibility case record, medical record, and any other Title XXI-related confidential and safeguarded information regarding a member, applicant, or unemancipated minor shall be released to individuals authorized by the member, applicant, or unemancipated minor only under the following conditions:
1. Authorization for release of information is obtained from the member, applicant, or designated representative;
2. Authorization used for release is a written document, separate from any other document, that specifies the following information:
   a. Information or records, in whole or in part, which are authorized for release;
   b. To whom release is authorized;
   c. The period of time for which the authorization is valid, if limited; and
   d. A dated signature of the adult and mentally competent member, applicant, or designated representative. If the member, or applicant is a minor, the signature of a parent, custodial relative, or designated representative shall be required. If the member, or applicant is mentally incompetent, authorization shall be according to A.R.S. § 36-509;
3. If an appeal or grievance is filed, the member, applicant, or designated representative shall be permitted to review

and obtain or copy any nonprivileged record necessary for the proper presentation of the case.

F. Release of safeguarded information to individuals or agencies for official purposes:

1. Official purposes directly related to the administration of the Title XXI program include:
   a. Establishing eligibility and premiums, as applicable;
   b. Determining the amount of medical assistance;
   c. Providing services for members;
   d. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the Title XXI program;
   e. Performing evaluations and analyses of Title XXI operations;
   f. Filing liens on property, as applicable;
   g. Filing claims on estates, as applicable; and
   h. Filing, negotiating, and settling medical liens and claims.
2. For official purposes related to the administration of the Title XXI program and only to the extent required in performance of duties, safeguarded information, including case records and medical records, may be disclosed to the following persons without the consent of the applicant or member:
   a. Employees of the Administration;
   b. Employees of the U.S. Social Security Administration;
   c. Employees of the Arizona Department of Economic Security;
   d. Employees of the Arizona Department of Health Services;
   e. Employees of the U.S. Department of Health and Human Services;
   f. Employees of contractors, providers, and subcontractors;
   g. Employees of the Arizona Attorney General's Office; or
   h. Qualifying community health centers as specified in A.R.S. § 36-2907.06 and hospitals as specified in A.R.S. § 36-2907.08.
3. Law enforcement officials:
   a. Information may be released to law enforcement officials without the applicant's, or member's written or verbal consent, for the purpose of an investigation, prosecution, or criminal or civil proceeding relating to the administration of the Title XXI program.
   b. Medical record. The Administration and contractors shall release safeguarded information contained in a member's medical record to law enforcement officials without the member's consent in situations of suspected of fraud or abuse against the Title XXI program.
   c. A contractor shall release the medical record or information in the case record or other information developed in case management or utilization management operations without the member's written or verbal consent, for the purpose of an investigation, prosecution, or similar criminal proceeding not in connection with the Administration, only if the law enforcement official requesting the information has statutory authority to obtain the information.
4. The Administration may release safeguarded information including case records and medical records to a review committee in accordance with the provisions of A.R.S. § 36-2986, without the consent of the applicant or member.
5. Providers shall furnish requested records to the Administration and its contractors at no charge.

G. The holder of a medical record of a former applicant or member shall obtain written consent from the former applicant or member before transmitting the medical record to a primary care provider.

H. Subcontractors are not required to obtain written consent from a member before transmitting the member's medical records to a physician who:

1. Provides a service to the member under subcontract with the program contractor,
2. Is retained by the subcontractor to provide services that are infrequently used or are of an unusual nature, and
3. Provides a service under the contract.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-513. Discrimination Prohibition

A. A contractor, provider, and nonprovider shall not discriminate against a member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental disability in accordance with Title VI of the U.S. Civil Rights Act of 1964, 42 U.S.C. 2000d, and rules and regulations promulgated according to, or as otherwise provided by law. For the purpose of providing covered service under contract according to A.R.S. Title 36, Ch. 29, discrimination includes, but is not limited to, the following if done on the grounds of the member's race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex, or physical or mental disability:

1. Denying or providing a member any covered service or availability of a facility;
2. Providing to a member any covered service that is different, or is provided in a different manner or at a different time from that provided to other Title XXI members under contract, other public or private members, or the public at large except when medically necessary;
3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; restricting a member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and
4. Assigning to a member times or places for the provision of services that are different from those assigned to other Title XXI members under contract.

B. A contractor shall take affirmative action to ensure that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental disability, except where medically indicated.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-514. Equal Opportunity

A contractor shall, in all solicitations or advertisements for employees placed by, or, on behalf of the contractor:

1. Specify that it is an equal opportunity employer;
2. Send a notice provided by the Administration to each labor union representative or worker with a collective bargaining agreement, or other contract or understanding, stating that the contractor is an equal opportunity employer; and

3. Post copies of the notice in conspicuous places available to employees and applicants for employment.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-515. Reserved
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R9-31-518. Information to Enrolled Members

A. As specified in A.R.S. § 36-2986, each contractor shall produce and distribute printed information materials to each member within 10 days of receipt of notification of enrollment from the Administration. The information materials shall be written in English and all languages used by 200 members or 5%, whichever is greater, of the enrolled population. The information materials must meet the requirements specified in the contractor's current contract.

B. A contractor shall provide a member with the name, address, and telephone number of the member's primary care provider within 10 days from the date of enrollment. This notice shall include information on how the member may change primary care providers, if dissatisfied with the primary care provider assigned.

C. A contractor shall revise and distribute to members a service guide insert describing any change that the contractor proposes to make in services provided or service locations. The insert shall be distributed to all affected members at least 14 days before a planned change. Notification shall be provided as soon as possible when unforeseen circumstances require an immediate change in services, sites or locations.

D. A contractor shall submit informational and educational materials for approval by the Administration before distributing the materials to members.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-519. Reserved
R9-31-520. Financial Statements, Periodic Reports and Information

A. Upon request by the Administration, a contractor shall furnish to the Administration information from its records relating to contract performance.

B. A contractor shall provide the Administration with the following:

1. An annual certified financial report prepared by a certified public accountant submitted no later than 120 days after the close of the contractor's fiscal year. The certified public accountants who prepare the report shall be independent of the contractor, subcontracting entities, their officers or directors, and any affiliates.
2. Quarterly financial statements no later than 60 days after the end of the reporting month.
3. Monthly financial statements, if required by the Administration submitted no later than 60 days after the end of the reporting period.
4. Disclosure of information on ownership and control required by 42 CFR 455, Subpart B, September 30, 1986, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
5. Cost reporting, audits, and financial reporting as specified in contract or provider agreement.

C. All financial statements shall identify separately all AHCCCS related transactions, including allocations of overhead and other shared expenses where applicable. A contractor shall provide supplemental schedules describing all inter-entity transactions and eliminations for the Administration to use in analyzing the financial status of the entire health care delivery system.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-521. Program Compliance Audits

A. As specified in A.R.S. § 36-2986, the Administration shall conduct a program compliance audit of a contractor at least once every 12 months during the term of its contract with the contractor. Unless the Administration determines that advance notice will render a program compliance audit less useful, a contractor will be notified approximately 3 weeks in advance of the date of an on-site program compliance audit. The Administration may conduct, without prior notice, inspections of contractor facilities or perform other elements of a program compliance audit, either in conjunction with the program compliance audit or as part of an unannounced inspection program.

B. A review team may perform any or all of the following procedures:

1. Conduct private interviews and group conferences with members, physicians, and other health professionals and members of the contractor's administrative staff including, but not limited to, the contractor's principal management persons;
2. Examine records, books, reports, and papers of the contractor and any management company, and all providers or subcontractors providing health care and other services to the health plan. The examination may include, but not be limited to: minutes of medical staff meetings, peer review and quality of care review records, duty rosters of medical personnel, appointment records, written procedures for the internal operation of the health plan, contracts and correspondence with members and with providers of health care services and other services to the plan, and additional documentation deemed necessary by the Administration to review the quality of medical care.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-522. Quality Management/Utilization Management (QM/UM) Requirements

A. As specified in A.R.S. §§ 36-2986 and 36-2990, a contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements specified in this Section and in contract. The contractor shall ensure compliance with QM/UM requirements that are accomplished through delegation or subcontract with another party.

B. A contractor shall:

1. Submit a written QM/UM plan that includes a description of the systems, methodologies, protocols, and procedures to be used in:
   a. Monitoring and evaluating the types of services,
   b. Identifying the numbers and costs of services provided,

c. Assessing and improving the quality and appropriateness of care and services,
d. Evaluating the outcome of care provided to members, and
e. Determining the steps and actions necessary to improve service delivery.

2. Submit the QM/UM plan on an annual basis within timelines specified in contract. If the QM/UM plan is changed during the year, the contractor shall submit the revised plan before implementation;
3. Receive approval from the Administration before implementing the initial QM/UM plan;
4. Ensure that a QM/UM committee operates under the control of the contractor's medical director, and includes representation from medical and executive management personnel. The committee shall:
   a. Oversee the development, revision and implementation of the QM/UM plan; and
   b. Ensure and allocate qualified QM/UM personnel and sufficient resources to implement the contractor's QM/UM activities.
5. Ensure that the QM/UM activities include at least:
   a. Prior authorization for non-emergency or scheduled hospital admissions;
   b. Concurrent review of inpatient hospitalization;
   c. Retrospective review of hospital claims;
   d. Program and provider audits designed to detect over or under utilization, service delivery effectiveness, and outcome;
   e. Medical records audits;
   f. Surveys to determine satisfaction of members;
   g. Assessment of the adequacy and qualifications of the contractor's provider network;
   h. Review and analysis of QM/UM data; and
   i. Other activities necessary to improve the quality of care and the efficient, cost effective delivery and utilization of services.

C. A member's primary care provider shall maintain medical records that:
1. Are detailed and comprehensive and identify:
   a. All medically necessary services provided to the member by the contractor and the subcontractors, and
   b. All emergency services provided by nonproviders for a member.
2. Conform to professional medical standards and practices for documentation of medical diagnostic and treatment data,
3. Facilitate follow-up treatment, and
4. Permit professional medical review and medical audit processes.

D. A subcontractor or its designee shall forward medical records or copies of medical records of all members assigned to the subcontractor or for whom the subcontractor has provided services, within 30 days following termination of a contract between the subcontractor and the contractor.

E. The Administration shall monitor contractors and their providers to ensure compliance with Administration QM/UM requirements and adherence to the contractor QM/UM plan.
1. A contractor and its providers shall cooperate with the Administration in the performance of its QM/UM monitoring activities, and
2. A contractor and its providers shall develop and implement mechanisms for correcting deficiencies identified through the Administration's QM/UM monitoring.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-523. Financial Resources

A. As specified in A.R.S. § 36-2986, a contractor or offeror shall demonstrate upon request to the Administration that it has:
1. Adequate financial reserves,
2. Administrative abilities, and
3. Soundness of program design to carry out its contractual obligations.

B. As specified in A.R.S. § 36-2986, the Director requires that contract provisions include, but not be limited to:
1. Maintenance of deposits,
2. Performance bonds,
3. Financial reserves, or
4. Other financial security.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-524. Continuity of Care

As specified in A.R.S. § 36-2986, a contractor shall establish and maintain a system to ensure continuity of care which shall, at a minimum, include:
1. Referring members who need specialty health care services,
2. Monitoring members with chronic medical conditions,
3. Providing hospital discharge planning and coordination including post-discharge care, and
4. Monitoring operation of the system through professional review activities as specified in A.R.S. § 36-2986.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-525. Reserved
R9-31-526. Reserved
R9-31-527. Reserved
R9-31-528. Reserved
R9-31-529. Reserved

ARTICLE 6. REQUEST FOR PROPOSAL (RFP)

R9-31-601. General Provisions for RFP

A. The Director has full operational authority to adopt rules or to use the appropriate rules for contract administration and oversight of contracts as specified in A.R.S. § 36-2986.

B. The Administration shall follow the provisions specified in 9 A.A.C. 22, Article 6 for offerors and are subject to the limitations and exclusions specified in that Article, unless otherwise specified in this Chapter.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-31-701. General; Scope of the Administration's Liability; and Payment to a Contractor

A. The Director has full operational authority to adopt rules or to use the appropriate rules adopted for the development and management of a contractor payment system as specified in A.R.S. §§ 36-2986 and 36-2987.

B. If the federal government eliminates federal funding for the program or significantly reduces the federal funding below the estimated federal expenditures, the Administration shall immediately stop processing all applications and shall provide at least 30 days advance notice to contractors and members that the program shall terminate as specified in A.R.S. § 36-2985.

C. The Administration shall bear no liability for providing covered services to or completing a plan of treatment for any member beyond the date of termination of the member's eligibility or enrollment as specified in A.R.S. § 36-2987.

D. The Administration shall make all payments to a contractor in accordance with the terms and conditions of the contract executed between the contractor and the Administration and in accordance with these rules as specified in A.R.S. § 36-2986.

E. The Administration shall bear no liability for subcontracts that a contractor executes with other parties for the provision of administrative or management services, medical services, or covered health care services, or for any other purpose. A contractor shall indemnify and hold the Administration harmless from any and all liability arising from the contractor's subcontracts, shall bear all costs of defense of any litigation over the liability, and shall satisfy in full any judgment entered against the Administration in litigation involving the contractor's subcontracts.

F. The Administration shall make capitation payments monthly to a contractor who meets the requirements in A.R.S. § 36-2987.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-702. Prohibitions Against Charges to Members

A. A contractor, subcontractor, or other provider of care or services shall not charge, submit a claim, demand, or otherwise collect payment from a member or a person acting on behalf of a member for any covered service except to collect an authorized co-payment or payment for additional services. A contractor shall have the right to recover from a member that portion of payment made by a 3rd party to the member when the payment duplicates Title XXI paid benefits and has not been assigned to the contractor. A contractor who makes a claim under this provision shall not charge more than the actual, reasonable cost of providing the covered services.

B. A provider shall not bill or make any attempt to collect payment, directly or through a collection agency, from an individual claiming to be Title XXI eligible without 1st receiving verification from the Administration that the individual was ineligible for Title XXI on the date of service or that the services provided were not covered by Title XXI as specified in A.R.S. § 36-2987.

C. A provider, including a noncontracting provider, may bill a member for medical expenses incurred during a period of time when the member willfully withheld material information from the provider or gave false information to the provider pertaining to the member's Title XXI eligibility or enrollment status that caused payment to be denied.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-703. Claims

A. Claims submission to contractors. A provider shall submit to a contractor all claims for services rendered to a member enrolled with the contractor.

B. Overpayments for Title XXI services. When a Title XXI overpayment is made to a contractor, the contractor shall notify the Administration that an overpayment was made. The Administration shall recoup an overpayment from a future claim cycle, or, at the discretion of the Director, require the contractor to return the incorrect payment to the Children's Health Insurance Program Fund.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-704. Transfer of Payments

A. Payments permitted. Payments may be made to other than the contractor as follows:

1. When payment is made in accordance with an assignment to a government agency or an assignment made according to a court order; or
2. When payment is made to a business agent, such as a billing service or accounting firm, who renders statements and receives payment in the name of a contractor providing that the agent's compensation for this service is:
   a. Reasonably related to the cost of processing the statements,
   b. Not dependent upon the actual collection of payment.

B. Prohibition of payments to factors. Payment for covered services furnished to a member by a contractor shall not be made to, or through a factor, either directly, or by virtue of a power of attorney given to the factor.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-705. Payments by Contractors

A. Authorization. A contractor shall pay for all admissions and covered services rendered to its members if the covered services or admissions have been arranged by the contractor's agents or employees, subcontracting providers, or other individuals acting on the contractor's behalf and if necessary authorization has been obtained. A contractor is not required to pay a claim for covered services that is submitted more than 6 months after the date of the service or that is submitted as a clean claim more than 12 months after the date of the service.

B. Timeliness of provider claim payment.

1. A contractor shall reimburse or provide written notice for a claim that is denied or reduced by a contractor to a subcontracting and a noncontracting provider for the provision of medically necessary health care services to a contractor's member, within the time period specified by the contract between a contractor and a subcontracting entity.
2. Unless the subcontract specifies otherwise, a contractor shall pay 90% of valid clean claims within 30 days of the date of receipt of a claim and 99% of valid the clean claims within 90 days of the date of receipt of a claim, as specified in 42 U.S.C. 1396u-2, as of August 5, 1997, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

3. The notice for a denied or a reduced claim shall be sent within the time-frames specified in this Section, and shall include a statement describing a provider's right to grieve the contractor's denial or reduction of the claim as specified in A.A.C. R9-22-Article 8.

C. Date of claim. A contractor's date of receipt of an inpatient or outpatient hospital claim shall be the date the claim is received by the contractor as indicated by the date stamp on the claim, the claim reference number, or the date-specific number system assigned by the contractor. A hospital claim shall be considered paid on the date indicated on the disbursement check. A denied hospital claim shall be considered adjudicated on the date of its denial. Claims that are pending for additional supporting documentation will receive new dates of receipt upon receipt of the additional documentation; however, claims that are pending for documentation other than the minimum required documentation specified in either A.R.S. §§ 36-2987 or 36-2904, as applicable, will not receive new dates of receipt. A contractor and a hospital may, through a contract approved in accordance with R9-31-715(A), adopt a method for identifying, tracking, and adjudicating claims that is different from the method described in this subsection.

D. Payment for medically necessary outpatient hospital services.

1. A contractor shall reimburse subcontracting and noncontracting providers for the provision of outpatient hospital services rendered at either a rate specified by subcontract or, in absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges. Subcontract rates, terms, and conditions are subject to review, and approval or disapproval under A.R.S. §§ 36-2987, 36-2904, and R9-31-715.
2. A contractor shall pay for all emergency care services rendered to its members by noncontracting providers or nonproviders when the services:
   a. Are rendered according to the prudent layperson standard,
   b. Conform to the definitions of emergency medical and acute mental health services in Article 1 of this Chapter, and
   c. Conform to the notification requirements in Article 2 of this Chapter.

E. Payment for inpatient hospital services. A contractor shall reimburse out-of-state hospitals for the provision of hospital services at negotiated discounted rates, the AHCCCS average cost-to-charge ratio multiplied by covered charges or, if reasonably and promptly available, the Medicaid rate that is in effect at the time services are provided in the state in which the hospital is located, whichever is lowest. A contractor shall reimburse in-state subcontractors and noncontracting providers for the provision of inpatient hospital services at either a rate specified by subcontract or, in absence of a subcontract, the prospective tiered-per-diem amount in A.R.S. §§ 36-2987, 36-2904, 36-2903.01, A.A.C. R9-22-712 and R9-22-718, as applicable. Discounts and penalties shall be as specified in A.R.S. § 36-2987(C). Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. §§ 36-2987, 36-2904, and R9-31-715.

F. Payment for observation days. A contractor may reimburse subcontracting and noncontracting providers for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges.

G. Review of hospital claims.

1. If a contractor and a hospital do not agree on reimbursement levels, terms, and conditions, the reimbursement levels established under A.R.S. §§ 36-2987, 36-2904, 36-2903.01, and A.A.C. R9-22-712 or R9-31-718 shall apply. In these cases, a hospital shall obtain prior authorization from the appropriate contractor for nonemergency admissions. A contractor shall consider the medical condition of the member, length of stay, and other factors when issuing its prior authorization. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of their contract regarding utilization control activities that may include prior authorization of nonemergency admissions. Failure to obtain prior authorization when it is required shall be cause for nonpayment or denial of the claim. A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and make the hospital's medical records, specific to a member enrolled with the contractor, available for review.
2. Regardless of prior authorization or concurrent review activities, all hospital claims, including outlier claims, are subject to prepayment medical review and post-payment review by the contractor. Post-payment reviews shall be consistent with A.R.S. § 36-2987, and erroneously paid claims are subject to recoupment. If prior authorization was given for a specific level of care, but medical review of the claim indicates that a different level of care was appropriate, the contractor may adjust the claim to reflect the more appropriate level of care. An adjustment in level of care shall be effective on the date when the different level of care was medically appropriate.
3. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures different from those in this subsection if the subcontract binds both parties and meets the requirements of R9-31-715.

H. Timeliness of hospital claim payment. Payment by a contractor for inpatient hospital admissions and outpatient hospital services shall be subject to A.R.S. §§ 36-2987, 36-2904, and 36-2903.01.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-706. Reserved

R9-31-707. Payments for Newborns

If a mother is enrolled on the date of her newborn baby's birth, a contractor shall be financially liable under the mother's capitation to provide all Title XXI-covered services to the newborn baby from the date of birth until the Administration is notified of the birth.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-708. Reserved

R9-31-709. Contractor's Liability to Hospitals for the Provision of Emergency and Subsequent Care

A. For purposes of program and contractor liability, an emergency medical or acute mental health condition of a member shall be subject to reimbursement only until the member's condition is stabilized and the member is transferable, or until the member is discharged following stabilization subject to the requirements of A.R.S. § 36-2989 and Article 2 of this Chapter.

B. Subject to subsection (A), if a member cannot be transferred following stabilization to a facility that has a subcontract with the contractor of record, the contractor of record shall pay for

all appropriately documented, prior authorized, and medically necessary treatment provided the member before the date of discharge or transfer in accordance with payment standards in R9-31-705.

C. If a member refuses transfer from a nonprovider or noncontracting hospital to a hospital affiliated with the member's contractor of record, neither the Administration nor the contractor shall be liable for any costs incurred after the date of refusal if:
1. After consultation with the member's contractor of record, the member continues to refuse the transfer; and
2. The member has been provided and signs a written statement, before the date of transfer of liability, informing the member of the medical and financial consequences of refusing to transfer. If the member refuses to sign a written statement, a statement signed by 2 witnesses indicating that the member was informed may be substituted.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-710. Reserved

R9-31-711. Copayments

A. Contractors shall be responsible for collecting a $5.00 copayment from a member for non-emergency use of the emergency room.

B. A contractor shall ensure that a member is not denied services because of the member's inability to pay a copayment.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-712. Reserved

R9-31-713. Payments Made on Behalf of a Contractor; Recovery of Indebtedness

A. The Administration may make payments on behalf of a contractor in order to prevent a suspension or termination of Title XXI services when either:
1. No payment period is specified by subcontract and a valid accrued claim is not paid within 30 days of receipt by the contractor, or
2. A valid accrued claim is not paid within the period under subcontract.

B. In the event a payment is made by the Administration according to this Article, the Administration shall reduce the capitation payment due a contractor by the amount of payment made, plus a 10% administrative fee for each claim that is paid.

C. If a contractor or a subcontracting provider receives an overpayment or otherwise becomes indebted to the Administration, the contractor or subcontracting provider shall immediately remit such funds to the Administration for deposit in the Children's Health Insurance Program Fund.

D. The action of the Administration to recover amounts from contractors or subcontracting providers may include the following:
1. Negotiation of a repayment agreement executed with the Administration.
2. Withholding or offsetting against current or future prepayments or other payments to be paid to the contractor or subcontracting provider.
3. Enforcement of, or collection against, the performance bond or withhold as specified in A.R.S. § 36-2986.

E. Except as specifically provided for in these rules, the Administration shall not be liable for payment for medical expenses incurred by members enrolled with contractors.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-714. Reserved

R9-31-715. Hospital Rate Negotiations

A. Effective for inpatient hospital admissions and outpatient hospital services contractors that negotiate with hospitals for inpatient or outpatient services shall reimburse hospitals for member care based on the prospective tiered-per-diem amount, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges in A.R.S. § 36-2987 and A.A.C. R9-22-712, or the negotiated rate that, when considered in the aggregate with other hospital reimbursement levels, does not exceed what would have been paid under A.R.S. § 36-2987 and A.A.C. R9-22-712.
1. Contractors may engage in rate negotiations with hospitals at any time during the contract period.
2. Within 7 days of the completion of the agreement process, contractors shall submit copies of their negotiated rate agreements, including all rates, terms, and conditions, with hospitals to the Administration for approval. Contractors shall demonstrate to the Administration that the effect of their negotiated rate agreement will, when considered in the aggregate, be the same as or produce greater dollar savings than would have been paid under A.R.S. § 36-2987 and A.A.C. R9-22-712.
   a. To demonstrate the aggregate effect of its negotiated rate agreement, contractors shall present their assumptions related to projected utilization of various hospitals to the Administration. The contractor may consider inpatient assumptions related to:
      i. Member mix;
      ii. Admissions by AHCCCS-specified tiers;
      iii. Average length of stay by tier and pattern of admissions, excluding emergency admissions;
      iv. Outliers; and
      v. Risk-sharing arrangements.
   b. The contractor also may consider outpatient assumptions related to member mix and outpatient service utilization. The Administration reserves the right to approve, deny, or require mutually-agreed-to modifications of these assumptions.
   c. When a contractor adjusts or modifies an assumption, the reason for the adjustment or modification shall be presented to the Administration, as well as the new assumption. The Administration may approve, deny, or require mutually-agreed-to modification of an assumption.
   d. To determine whether a negotiated rate agreement produces reimbursement levels that do not in the aggregate exceed what would be paid under A.R.S. § 36-2987 and A.A.C. R9-22-712, a contractor shall require its independent auditors to evaluate the reasonableness of its assumptions as part of its annual audit. The contractor shall ensure that its independent auditor's audit program is consistent with AHCCCS audit requirements and is submitted to the Administration for prior approval.
   e. Negotiated inpatient or outpatient rate agreements with hospitals with a contractor has a related-party interest are subject to additional related party disclo-

sure and evaluation. These evaluations are in addition to the procedures described in subsection (A)(2)(c) and shall be performed by the contractor's independent auditors, or, at the contractor's option, by the Administration.

f. The Administration shall subject a contractor's independent auditor's report to any examination or review necessary to ensure accuracy of all findings related to aggregate rate determinations.

g. The Administration shall use its standards, consistent with the Request for Proposals and R9-31-502, to determine whether a contractor's inpatient or outpatient hospital subcontractors will limit the availability or accessibility of services. The Administration reserves the right to reject hospital subcontracts that limit the availability or accessibility of services.

B. The Administration may negotiate or contract with a hospital on behalf of a contractor for discounted hospital rates and may require that the negotiated discounted rates be included in a subcontract between the contractor and hospital.

C. The Director shall apportion any cost avoidance in the hospital component of provider capitation rates between the Administration and provider. The Administration's portion of the cost avoidance shall be reflected in reduced capitation rates paid to providers.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-716. Specialty Contracts

The Director may at any time negotiate or contract on behalf of contractors for specialized hospital and medical services including, but not limited to, transplants, neonatology, neurology, cardiology, and burn care. If the Director contracts for specialized services, contractors of record may be required to include the services within their delivery networks and make contractual modifications necessary to carry out this Section. Specialty contractors shall take precedence over all other contractual arrangements between contractors of record and their subcontractors. Specialty contractors may require interim payments to specialty contractors on behalf of contractors of record for contract services received by members. Interim payments to specialty contractors may be deducted from capitation payments, performance bonds, or other monies for payment on behalf of contractors of record. If the Administration and a hospital that performed a transplant surgery on a member does not have a contracted rate, the system shall not reimburse the hospital more than the contracted rate established by the Administration.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-717. Hospital Claims Review

A. The contractors shall review hospital claims that are timely received as specified in A.A.C. R9-22-703(B).

B. A charge for hospital services provided to a member during a time when the member was not the financial responsibility of the contractor shall be denied.

C. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:

1. Patient care kit,
2. Toothbrush,
3. Toothpaste,
4. Petroleum jelly,
5. Deodorant,
6. Septi soap,
7. Razor,
8. Shaving cream,
9. Slippers,
10. Mouthwash,
11. Disposable razor,
12. Shampoo,
13. Powder,
14. Lotion,
15. Comb, and
16. Patient gown.

D. The following hospital supplies and equipment, if medically necessary and used, are covered services:

1. Arm board,
2. Diaper,
3. Underpad,
4. Special mattress and special bed,
5. Gloves,
6. Wrist restraint,
7. Limb holder,
8. Disposable item used in lieu of a durable item,
9. Universal precaution,
10. Stat charge, and
11. Portable charge.

E. The hospital claims review shall determine whether services rendered were:

1. Title XXI-covered services;
2. Medically necessary;
3. Provided in the most appropriate, cost-effective, least restrictive setting; and
4. Substantiated by the minimum documentation specified in A.R.S. §§ 36-2987.

F. If a claim is denied by the contractor, a grievance challenging the denial may be filed against the entity denying the claim. The grievance shall be filed no later than 12 months from the date of service or 60 days from the date of notice of adverse action, whichever is latest. Any grievance challenging a post-payment review recoupment action shall be filed by the provider no later than 12 months from the date of service or 60 days from the date of the notice of recoupment, whichever is latest.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

ARTICLE 8. GRIEVANCE AND APPEAL PROCESS

R9-31-801. General Provisions For All Grievances and Appeals

A. As specified in A.R.S. § 36-2986, the Director shall, by rule, establish a grievance and appeal procedure.

B. All grievances and appeals shall be filed and processed according to A.A.C. R9-22-801. In eligibility appeals, the Administration is the respondent.

C. The AHCCCS chief hearing officer or designee may deny a request for a hearing if either of the following occurs:

1. The sole issue presented is a federal or state law requiring an automatic change adversely affecting some or all applicants or members, or
2. The Administration reaches the maximum number of members the program shall serve as specified in A.R.S. § 36-2985.

D. A parent or legal guardian may file a grievance only over a denial of a covered service or a claim for a covered service, as specified in R9-31-803. A parent or legal guardian may not

file an eligibility appeal and is not entitled to receive a continued service on appeal. If the parent or legal guardian prevails in the AHCCCS grievance process, the contractor shall provide any service or pay any claim determined to be medically necessary regardless of whether judicial review is sought. A provider may file a grievance regarding a denial of a covered service or a claim for a covered service of a parent or legal guardian.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-802. Eligibility Appeals and Hearing Requests for an Applicant and a Member

A. Adverse eligibility actions. An applicant or a member may appeal and request a hearing concerning either of the following adverse eligibility actions:
1. Denial of eligibility, or
2. Discontinuance of eligibility.

B. Notice of an adverse eligibility action. Notice of an adverse eligibility action shall be personally delivered or mailed to the affected individual by regular mail. For purposes of this Section, the date of the Notice of Action shall be the date of personal delivery to the individual or the postmark date, if mailed.

C. Appeals and requests for hearing.
1. An applicant or a member may appeal and request a hearing regarding an adverse eligibility action by completing and submitting the AHCCCS Request for Hearing form or by submitting a written request containing the following information:
   a. The case name,
   b. The adverse eligibility action being appealed, and
   c. The reason for appeal.
2. For denials, the request for hearing shall be filed not later than 20 days from the date of the notice of adverse action. For discontinuances, the request for hearing shall be filed not later than 10 days after the effective date of action. The request for hearing shall be filed by mailing or delivering it to either the Title XXI eligibility office or the Administration, Office of Grievance and Appeals. For this Section only, the date of the request for hearing shall be the postmark date, if mailed, or the date of personal delivery.

D. Eligibility office responsibilities.
1. The eligibility office shall maintain a register which documents the date on which a request for hearing is submitted.
2. If requested, the eligibility office shall assist the appellant or designated representative in the completion of the Request for Hearing form.
3. A Pre-Hearing Summary shall be completed by the eligibility office and shall summarize the facts and factual basis for the adverse eligibility action.
4. The eligibility office shall send to the Administration, Office of Grievance and Appeals, the Pre-Hearing Summary, a copy of the case file, documents pertinent to the adverse action, and the Request for Hearing, which must be received by the Administration, Office of Grievance and Appeals, not later than 10 days from the date the request is received. If the request is submitted directly to the Administration, Office of Grievance and Appeals, the eligibility office shall send the materials to the Office of Grievance and Appeals, not later than 10 days from the date of a request for the materials.

E. Title XXI coverage during the appeal process.
1. Applicants appealing a denial of Title XXI coverage. A denial is an adverse eligibility decision which finds the applicant ineligible for Title XXI benefits. In the event that a timely request for hearing is filed and the denial is overturned, the effective date of Title XXI coverage shall be established by the Director in accordance with applicable law.
2. Members appealing a discontinuance. A discontinuance is a termination of Title XXI benefits. For actions requiring 10 days advance notice, a member who requests a hearing before the effective date of the adverse action shall continue to receive Title XXI benefits until an adverse decision on the appeal is rendered, unless the program is suspended or terminated as specified in A.R.S. § 36-2985.
3. Member's financial responsibility for benefits. A member whose benefits have been continued shall be financially liable for all Title XXI benefits received during a period of ineligibility if a discontinuance decision is upheld by the Director.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-803. Grievances

All grievances regarding Title XXI shall be filed and processed according to A.A.C. R9-22-804. For purposes of this Chapter, a member's grievance does not need to state with particularity the legal or factual basis for the requested relief.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-804. Grievance and Appeal Process for Behavioral Health

A. All Title XXI grievances relating to an adverse action, decision, or policy regarding behavioral health issues shall be processed according to the standards set by the Administration, as specified in contract with ADHS, contractors, and provider agreements.

B. An appeal of a grievance decision under subsection (A) shall be conducted as a contested case according to R9-31-801 and R9-31-803.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

ARTICLE 9. QUALITY CONTROL

R9-31-901. General Provisions

A. The Director has full operational authority to adopt rules or to use the appropriate rules for administration and oversight of quality control as specified in A.R.S. § 36-2986.

B. As specified in A.R.S. § 36-2982, the Administration has the authority to establish a process to audit eligibility determinations made by AHCCCS or the entities with which the Administration contracts or enters into an intergovernmental agreement.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

ARTICLE 10. 1ST- AND 3RD-PARTY LIABILITY AND RECOVERIES

R9-31-1001. 1st- and 3rd-Party Liability and Coordination of Benefits

A. General provisions.
1. As specified in A.R.S. §§ 36-2986 and 36-2987, the Director has full operational authority to adopt rules or to use the appropriate rules adopted for coordination of benefits provided under this Article for any member.
2. The Administration may subcontract distinct administrative functions as permitted by A.R.S. § 36-2986.

B. Cost avoidance. The System shall cost avoid all claims or services that are subject to 1st- or 3rd-party liability source, and may deny a service to a member if it knows that a 1st- or 3rd-party will provide the service. The requirement to cost avoid applies to all Title XXI covered services, unless otherwise specified in this Section.
1. Responsible parties. The following parties shall take reasonable measures to identify legally liable 1st- or 3rd-party sources:
   a. Administration,
   b. Contractor,
   c. Provider,
   d. Nonprovider,
   e. Noncontracting provider, and
   f. Member.
2. Coordination of benefits. As specified in A.R.S. § 36-2986, if a contractor does not know whether a particular service is covered by a 1st- and 3rd-party insurer, and the service is medically necessary, the contractor shall contact the 1st- and 3rd-party, and determine whether the service is covered rather than requiring a member to contact the 1st- or 3rd-party. If the contractor knows that the 1st- and 3rd-party insurer will neither pay for nor provide the covered service, and the service is medically necessary, the contractor shall neither deny the service nor require a written denial letter.
3. Copayment, coinsurance, deductible. If a 1st- or 3rd-party insurer (other than Medicare) requires a member to pay any copayment, coinsurance, or deductible, the contractor must decide whether it is more cost effective to provide the service:
   a. Within its network for continuity of care, or
   b. Outside its network for continuity of care under the following conditions:
      i. Advance payments. If an insurer requires payment in advance of a copayment, coinsurance, or deductible, the contractor shall make the payment in advance for the member.
      ii. Limitation of copayment, coinsurance, and deductible amounts. A contractor that meets the requirements in subsection (B)(5) is not responsible for paying a copayment, coinsurance, or deductible that is in excess of what the contractor would have paid for the entire service, per a written contract with the provider performing the service minus any amount paid by the 1st- and 3rd-party.
4. Exceptions. A contractor shall provide the following services, and then coordinate payment with a 1st- and 3rd-party payor:
   a. Emergency service, and
   b. Emergency transportation as specified in A.R.S. § 36-2989.
5. Medically necessary service. A contractor shall ensure that its cost avoidance efforts do not prevent a member from receiving a medically necessary service, and that a member is not required to pay any copayment, coinsurance, or deductible for use of the other insurer's provider;
6. Pre-natal and preventive services. The Administration may require a contractor to provide pre-natal and preventive pediatric services, and then coordinate payment with a liable 1st- or 3rd-party.

C. Member participation. A member shall cooperate in identifying potentially liable 1st- or 3rd- parties and assist the Administration, contractor, provider, nonprovider, or noncontracting provider in pursuing any 1st- or 3rd-party who may be liable to pay for covered services.

D. Collections.
1. The following parties shall cooperate, identify, and notify the Administration of all potential sources of 1st- or 3rd-party liability:
   a. Provider,
   b. Nonprovider, and
   c. Noncontracting provider.
2. The following parties shall pursue collection or reimbursement from all potential sources of 1st- or 3rd-party liability:
   a. The Administration,
   b. Provider,
   c. Nonprovider, and
   d. Noncontracting provider.
3. Contractors shall cooperate, identify, and notify the Administration of all potential sources of 1st- or 3rd-party liability and pursue collection or reimbursement according to R9-31-1002(B).
4. Recoveries: Contractor. A contractor may retain up to 100% of its 1st- and 3rd-party collections if:
   a. Total payments received do not exceed the total amount of the contractor's financial liability for the member. Payments in excess of the contractor's liability shall be reimbursed as described in 42 CFR 433.154, May 12, 1980, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments,
   b. Title XXI reinsurance benefits or both have not duplicated the recovery. Any duplicated benefits received shall be reimbursed to the Administration. Payments by the Administration for covered services may supplement payment or benefits from 1st- or 3rd-parties to the extent authorized by this Chapter or applicable contracts,
   c. The recovery is not prohibited by federal or state law, and
   d. The payments collected are reflected in reduced capitation rates. The Administration may require a contractor to reimburse the Administration up to 100% of collected 1st- and 3rd-party payments that are not reflected in reduced capitation rates.
5. Recoveries: Administration. The Administration may retain its 1st- and 3rd-party collections, reinsurance payments, administrative costs, capitation payments, and any other payments made by the System. The funds collected shall be deposited in the Children's Health Insurance Program Fund as specified in A.R.S. § 36-2995.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1002. 1st- and 3rd-Party Liability Monitoring and Compliance

A. 1st- or 3rd-party liability sources. The Administration shall monitor 1st- or 3rd-party liability payments to a contractor, provider, nonprovider, or noncontracting provider, which may include but are not limited to payments by or for:
1. Private health insurance;
2. Employment related disability and health insurance;
3. Other federal programs not excluded by statute;
4. Court ordered or non-court ordered medical support from an absent parent;
5. State worker's compensation;
6. Automobile insurance, including underinsured and uninsured motorists insurance;
7. Court judgment or settlement from a liability insurer including settlement proceeds placed in a trust;
8. First-party probate estate recovery;
9. Adoption related payment; and
10. Tortfeasor.

B. Contractor responsibility. A contractor shall:
1. Recover 1st- and 3rd-party payments from the sources identified in subsections (A)(1) through (4); and
2. Recover 1st- and 3rd-party payments from the sources identified in subsections (A)(5) through (8), when directed by the Administration.

C. Monitoring. The Administration shall determine whether a contractor, provider, nonprovider, or noncontracting provider is in compliance with the requirements in this Article by inspecting claim submissions and payment documentation for cost avoidance and recovery activities.

D. Notification for perfection, recording, and assignment of Title XXI liens.
1. County requirements. The Administration may preserve its lien rights according to A.R.S. §§ 36-2986(M), 36-2915 and 36-2916.
2. Hospital requirements. Hospitals providing emergency or urgent medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a 1st- or 3rd-party shall notify the Administration according to subsection (E) within 30 days after discharge. A hospital may satisfy the requirement of this subsection also by mailing to the Administration a copy of the lien it proposes to record or has recorded according to A.R.S. § 36-2986 within 30 days after discharge.
3. Contractor, provider, nonprovider, and noncontracting provider requirements. A contractor, provider, nonprovider, or noncontracting provider, other than a hospital, rendering medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a 1st- or 3rd-party shall notify the Administration according to subsection (E) within 30 days after providing the services.

E. Notification information for liens. To satisfy notification requirements, all of the following information shall be mailed to the Administration:
1. Name of the contractor, provider, nonprovider, or noncontracting provider;
2. Address of the contractor, provider, nonprovider, or noncontracting provider;
3. Name of the member;
4. The member's Social Security number or Title XXI identification number;
5. Address of the member;
6. Date of the member's admission;
7. Amount estimated to be due for care of the member;
8. Date of the member's discharge;
9. Name of county in which injuries were sustained; and
10. Name and address of all persons, firms, and corporations and their insurance carriers claimed by the member or legal representative to be liable for damages.

F. Notification of health insurance information. A contractor, provider, nonprovider, or noncontracting provider shall provide notification of health insurance information to the Administration. To satisfy notification requirements, all of the following health insurance information shall be submitted to the Administration within 10 days of receipt of the health insurance information:
1. Name of the member;
2. The member's Social Security number or Title XXI identification number;
3. Insurance carrier name;
4. Insurance carrier address;
5. Policy number, if available;
6. Policy begin and end dates, if available; and
7. Insured's name and Social Security number.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS

R9-31-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims

A. Establishment and management of a system to prevent fraud. As specified in A.R.S. § 36-2986(A), the Director has full operational authority to adopt rules for the establishment and management of a system to prevent fraud by members, contractors, and health care providers.

B. Determination and collection of civil penalties. As specified in A.R.S. §§ 36-2991 and 36-2993 the Director may adopt rules that prescribe procedures for the determination and collection of civil penalties.

C. Federal fraud and abuse controls. As specified in A.R.S. § 36-2991, in addition to the requirements of state law, any applicable fraud and abuse controls that are enacted under federal law apply to a person who is eligible for services under this Chapter and to contractors and noncontracting providers who provide services under this Chapter.

D. Unpaid civil penalties. As specified in A.R.S. § 36-2991, if a civil penalty imposed according to this Article is not paid, the state may file an action to collect the civil penalty in the superior court in Maricopa county.

E. Circumstances for imposing a penalty and assessment. The Director or designee shall impose a penalty and assessment under the circumstances described in A.R.S. § 36-2991. For the purposes of this Article, the term "reason to know" means that a person, with respect to information, acts in deliberate ignorance of the truth or falsity of the information or with reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

F. Violation of agreement. As specified in A.R.S. § 36-2992, the Director's or designee's determination of whether a person knew or had reason to know that each claim or request for payment was claimed in violation of an agreement with the Administration or a contractor may be based on the terms of the agreement.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Ses-

sion, effective October 23, 1998 (Supp. 98-4).

R9-31-1102. Determinations Regarding the Amount of the Penalty and Assessment

A. Factors for determining a penalty and assessment. The Director or designee shall take into account the following factors in determining the amount of a penalty and assessment:
1. The nature of each claim or request for payment and the circumstances under which it is presented,
2. The degree of culpability of a person submitting each claim or request for payment,
3. The history of prior offenses of a person submitting each claim or request for payment,
4. The financial condition of a person presenting each claim or request for payment,
5. The effect on patient care resulting from the failure to provide medically necessary care by a person submitting each claim or request for payment, and
6. Other matters as justice may require.

B. Types of claim circumstances. As specified in A.R.S. § 36-2991, in determining the amount of a penalty and assessment, the Director or designee shall consider both mitigating circumstances and aggravating circumstances surrounding submission of each claim or request for payment.

C. Mitigating circumstance guidelines. The Director or designee shall consider the following mitigating circumstance guidelines when determining the amount of a penalty and assessment:
1. Nature and circumstances of each claim or request for payment. The nature and circumstances of each claim or request for payment and the circumstances under which it is presented are a mitigating circumstance if:
   a. All the items and services subject to a penalty and assessment are of the same type,
   b. All the items and services subject to a penalty and assessment occurred within a short period of time,
   c. There are few items and services, and
   d. The total amount claimed for the items and services was less than $1,000.
2. Degree of culpability. The degree of culpability of a person submitting a claim or request for payment is a mitigating circumstance if:
   a. Each item or service is the result of an unintentional and unrecognized error in the process the person followed in presenting the item or service,
   b. Corrective steps were taken promptly after the error was discovered, and
   c. A fraud and abuse control plan was adopted and operating effectively at the time each claim or request for payment was submitted.
3. Financial condition. The financial condition of a person presenting a claim or request for payment is a mitigating circumstance if the imposition of a penalty and assessment without reduction will jeopardize the ability of the person to continue as a health care provider. The resources available to the person may be considered when determining the amount of the penalty and assessment; or
4. Other matters as justice may require. Other circumstances of a mitigating nature will be taken into account if, in the interest of justice, the circumstances require a reduction of the penalty and assessment.

D. Aggravating circumstance guidelines. The Director or designee shall consider the following aggravating circumstance guidelines when determining the amount of a penalty and assessment:
1. Nature and circumstances of each claim or request for payment. The nature and circumstances of each claim or request for payment and the circumstances under which it is presented are an aggravating circumstance if:
   a. The items and services subject to a penalty and assessment are of several types,
   b. The items and services subject to a penalty and assessment occurred over a lengthy period of time,
   c. There are many items or services (or the nature and circumstances indicate a pattern of claims for the items or services), or
   d. The total amount claimed for the items and services is $1,000 or greater.
2. Degree of culpability. The degree of culpability of a person submitting each claim or request for payment is an aggravating circumstance if:
   a. The person knew that each item or service was not provided as claimed;
   b. The person knew that no payment could be made because the person had been excluded from system reimbursement; or
   c. Payment would violate the terms of an agreement between the person and the state, the Administration or a contractor.
3. Prior offenses. The prior offenses of a person submitting each claim or request for payment is an aggravating circumstance if, at any time before the presentation of any claim or request for payment subject to a penalty and assessment under this Article, the person was held liable for a criminal, civil, or administrative sanction in connection with:
   a. A Medicaid program,
   b. A Medicare program,
   c. A Title XXI program, or
   d. Any other public or private program of reimbursement for medical services.
4. Effect on patient care. The seriousness of an adverse effect that resulted, or could have resulted, from the failure of a person submitting a claim or request for payment to provide medically necessary care is an aggravating circumstance; or
5. Other matters as justice may require. Other circumstances of an aggravating nature shall be taken into account if, in the interest of justice, the circumstances require an increase of the penalty and assessment.

E. Amount of penalty and assessment. As specified in A.R.S. § 36-2993 and this Article, the aggregate amount of a penalty and assessment shall never be less than double the approximate amount of damages sustained by the State, the Administration or contractor, unless there are extraordinary mitigating circumstances.

F. Compromise. The Director or designee may compromise a penalty and assessment using the guidelines in subsections (C) and (D).

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1103. Notice of Proposed Determination and Rights of Parties

A. Administration's responsibilities. If the Director or designee proposes to impose a penalty and assessment, the Director or designee shall deliver or send by certified mail, return receipt requested, to a person, written notice of intent to impose a penalty and assessment. The notice shall include:
1. Reference to the statutory basis for the penalty and assessment,

2. A description of each claim or request for payment for which the penalty and assessment are proposed,
3. The reason why each claim or request for payment subjects the person to a penalty and assessment, and
4. The amount of the proposed penalty and assessment.

B. Individual's responsibilities. A person may submit within 35 days from the date of the adverse action:
1. A written statement accepting imposition of the penalty and assessment,
2. As specified in A.R.S. § 36-2993 a written request for a compromise of the penalty and assessment stating any reasons that the person contends should result in a reduction or modification of the penalty and assessment. If a request is submitted, the time period for filing an appeal and request for hearing according to subsection (C) shall be tolled until the Director's or designee's decision on the request for compromise, or
3. A grievance in accordance with the provider grievance provision in 9 A.A.C. 31, Article 8 of this Chapter.

C. The Director or designee may impose a proposed penalty and assessment or any less severe penalty and assessment if a person does not request a hearing within the time prescribed by subsections (B)(2) or (3). A person has no right to appeal a penalty and assessment if the person has not timely requested a hearing.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1104. Issues and Burden of Proof

A. Preponderance of evidence. In any hearing conducted according to this Article, the Director or designee shall prove by a preponderance of the evidence that a person who requested a hearing presented or caused to be presented each claim or request for payment in violation of R9-31-1101. A person who requests a hearing shall bear the burden of producing and proving by a preponderance of the evidence any circumstance that would justify reducing the amount of the penalty and assessment.

B. Statistical sampling.
1. The Director or designee may introduce the results of a statistical sampling study as evidence of the number and amount of claims or requests for payment that were presented or caused to be presented by the person in meeting the burden of proof described in subsection (A). A statistical sampling study shall constitute prima facie evidence of the number and amount of claims or requests for payment, if based upon an appropriate sampling and computed by valid statistical methods.
2. The burden of proof shall shift to the person to produce evidence reasonably calculated to rebut the findings of the statistical sampling study once the Director or designee has made a prima facie case as described in subsection (A). The Director or designee will be given the opportunity to rebut this evidence.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

ARTICLE 12. COVERED BEHAVIORAL HEALTH SERVICES

R9-31-1201. General Requirements

A. The Administration shall administer the program as specified in A.R.S. § 36-2982 and behavioral health services shall be provided in compliance with A.R.S. § 36-2989 and this Chapter.

B. The Director has full operational authority to adopt rules or to use the appropriate rules adopted as specified in A.R.S. § 36-2986. Specifications in this Article shall apply to:
1. ADHS, RBHAs and a behavioral health provider under contract with a RBHA; and
2. A contractor and its subcontracted behavioral health providers.

C. Behavioral health services shall be provided through an IGA with ADHS for a member enrolled with a RBHA and who is under 18 years of age, or is 18 years of age and determined SMI. ADHS shall:
1. Contract with a RBHA for the provision of, at a minimum, behavioral health services specified in this Article and in contract. A RBHA shall provide services directly or through subcontract with qualified service providers within and, if unavailable, outside their service areas.
2. Use its established diagnostic and evaluation program for referral of a child who is not already enrolled and who may be in need of behavioral health services. In addition to an evaluation, the ADHS shall also identify a child who may be eligible under A.R.S. §§ 36-2901 or 36-2931 and shall refer the child to the appropriate agency responsible for making the final eligibility determination.
3. Refer a member who is 18 years old who is not SMI to a member's assigned contractor for behavioral health services.

D. A contractor shall provide, at a minimum, behavioral health services specified in this Article and in contract for a member who is 18 years of age and is not SMI. A contractor shall:
1. Provide services directly or through subcontract with qualified behavioral health providers within and, if unavailable, outside their service areas.
2. Refer a member who is under 18 years of age, or who is 18 years old and SMI, to a RBHA for behavioral health services.
3. For a member other than an 18 year old non-SMI, emergency crisis stabilization services not to exceed three days per episode and 12 days per year contract year for a member not yet enrolled with a RBHA.

E. ADHS, its subcontractors and AHCCCS acute care contractors shall cooperate as specified in contract when a transition from one entity to another becomes necessary. For a Title XXI member, this transition shall include tracking and reporting of services used by a member toward the annual limitations prior to the transfer of care.

F. Behavioral health services provided to a member shall be medically necessary and provided in collaboration with the member's primary care provider.

G. Services shall be rendered in accordance with state and federal laws and regulations, the *Arizona Administrative Code* and AHCCCS contractual requirements.

H. Experimental services as determined by the Director, or services provided primarily for the purpose of research, shall not be covered.

I. Services or items, if furnished gratuitously, are not covered and payment shall be denied.

J. Behavioral health services shall not be covered if provided to:
1. An inmate of a public institution;
2. A person who is a resident of an institution for the treatment of tuberculosis; or
3. A person who is in an institution for the treatment of mental diseases at the time of application, or at the time of redetermination.

K. Services shall be provided by personnel or facilities, appropriately licensed or certified to provide the specific service and registered with AHCCCS.

L. Payment for services or items requiring prior authorization may be denied if prior authorization is not obtained.
1. Prior authorization for behavioral health services provided to a RBHA member shall be obtained from a RBHA in which a member is enrolled.
2. A contractor shall provide prior authorization for a behavioral health service to be provided to a member not yet enrolled with a RBHA and an 18 year old non-SMI member.
3. An emergency behavioral health service does not require prior authorization. Services for unrelated conditions, requiring additional diagnostic and treatment procedures, require additional prior authorization from the responsible contractor.

M. Behavioral health services rendered to a member shall be provided within the member's service area except when:
1. A covered service that is medically necessary for a member is not available within the service area;
2. A net savings in behavioral health service delivery costs can be documented without requiring undue travel time or hardship for a member or a member's family;
3. A member is placed in a treatment facility located out of the service area; or
4. The service is otherwise authorized based on practice patterns, and cost or scope of service considerations.

N. When a member is traveling or temporarily residing out of the service area, covered services are restricted to emergency care, unless otherwise authorized by the member's RBHA or contractor.

O. If a member requests the provision of a behavioral health service that is not covered under these rules or is not authorized, the service may be rendered to a member by an AHCCCS-registered behavioral health service provider under the following conditions:
1. A document that lists the requested services and the itemized cost of each is prepared and provided to a member; and
2. The signature of the member, or the member's guardian, is obtained in advance of service provision indicating that the services have been explained to the member or guardian and that the member or guardian accepts responsibility for payment.

P. If a member is referred out of the contractor's service area to receive an authorized medically necessary behavioral health service for an extended period of time, all other medically necessary covered services for the member shall also be provided by the contractor during that time.

Q. The restrictions, limitations, and exclusions in this Article shall not apply to a contractor and a ADHS RBHA when electing to provide a noncovered service.
1. The costs associated with providing any noncovered service to a member shall not be included in development or negotiation of capitation.
2. Noncovered services shall be paid from administrative revenue or other funds, unrelated to Title XXI services.

R. Behavioral health and substance abuse disorders are covered services in this Article.

S. The grievance and appeal process specified in 9 A.A.C. 31, Article 8 shall apply to behavioral health services.

T. Payment terms and conditions specified in 9 A.A.C. 31, Article 7 shall apply to a contractor and a ADHS RBHA for behavioral health services.

U. Quality management and utilization management requirements specified in 9 A.A.C. 31, Article 5 shall apply to a behavioral health service delivery.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1202. Inpatient Behavioral Health Services

A. Inpatient care shall include accommodations and appropriate staffing, supplies, equipment and behavioral health services. Services shall be provided in:
1. A general acute care hospital,
2. A psychiatric hospital, or
3. An inpatient psychiatric facility for persons under 21 years of age.

B. The following limitations shall apply to inpatient care:
1. Services are limited to a maximum of 30 days during each contract year.
2. Only psychiatrists, certified psychiatric nurse practitioners, and psychologists may bill independently for authorized services provided. All other services shall be included in the facility reimbursement rate. Professional services by psychiatrists, certified nurse practitioners, and psychologists, which are provided in an inpatient setting do not count toward the 30 day 30 visit annual limitation.
3. Medical detoxification services may be initially authorized for up to 4 days. When medically necessary, additional days may be authorized if ordered by a psychiatrist or certified psychiatric nurse practitioner and approved by a Medical Director of a RBHA or a contractor.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1203. Partial Care

A. Partial care shall be provided on either an intensive or basic level of care as medically necessary to meet a member's needs for behavioral health treatment and prevent placement in a higher level of care or more restrictive environment.

B. The following limitations shall apply to partial care services:
1. Services are counted toward the maximum of 30 days during each contract year.
   a. Each full day of partial care, basic or intensive, counts as 1/2 day of inpatient care.
   b. Each 1/2 day of partial care, basic or intensive, counts as 1/4 day of inpatient care.
2. Intensive partial care services shall be limited to a member whose emotional, behavioral, or substance abuse problems indicates a serious emotional disturbance and or both evidence of abuse or neglect.
3. Prevocational or vocational activities, school attendance and educational hours shall not be included as an intensive and basic partial care service and shall not be billed simultaneously with these services.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1204. Outpatient Services

A. Outpatient services as specified in contract shall include the following services:
1. Evaluation and diagnosis;

2. Counseling including individual therapy, group and family therapy;
3. Behavior management; and
4. Psycho-social rehabilitation.

B. The following limitations shall apply to outpatient services:
1. The total number of all outpatient services shall not exceed a maximum of 30 visits during each contract year.
2. Each outpatient service except group therapy or group counseling shall count as 1 visit. Each group therapy or group counseling service shall count as 1/2 visit.
3. Only psychiatrists, certified psychiatric nurse practitioners and psychologists may bill independently for services provided.
4. Other behavioral health professionals and behavioral health technicians shall be affiliated with, and their services billed through, a licensed behavioral health agency.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1205. Behavioral Health Emergency and Crisis Stabilization Services

A. Behavioral health emergency and crisis stabilization services may be provided on either an inpatient or outpatient basis by qualified personnel and be available 24 hours per day, 7 days per week in each RHBA's service area.

B. Consultation provided by a psychiatrist, a certified psychiatric nurse practitioner, or a psychologist shall be covered as an emergency service if required to evaluate or stabilize an acute episode of mental illness or substance abuse.

C. Limitations on behavioral health emergency or crisis stabilization services:
1. Contractors shall provide inpatient behavioral health emergency or crisis stabilization services not to exceed 3 days per episode and 12 days per year, from the time of a member's enrollment under Title XXI, for a member who is under age 18 or is 18 years old and SMI, but not enrolled with a RHBA.
2. Inpatient service limitations shall apply to emergency or crisis stabilization services provided on an inpatient basis as specified in R9-31-1202(B).
3. Emergency or crisis intervention services provided on an outpatient basis by a psychiatrist, certified psychiatric nurse practitioner, psychologist, or qualified facility shall not count towards the outpatient service limitation as specified in R9-31-1204(B)(1) and (2).

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1206. Other Behavioral Health Services

The following services are covered but are not included in the visit limitations:
1. Laboratory and radiology services for behavioral health diagnosis and medication management;
2. Psychotropic medication(s) included in the Title XXI formulary of a member's RBHA or contractor;
3. Medication monitoring, administration and adjustment for psychotropic medications; and
4. Case management to identify, obtain and coordinate Title XXI behavioral health services as specified in contract.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1207. Transportation Services

A. Emergency transportation shall be covered for behavioral health emergencies as specified in R9-31-211 and shall be limited to situations where there is an imminent threat of harm to the member if care is not rendered expeditiously.

B. Non-emergency transportation for behavioral health services is excluded.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

ARTICLE 13. MEMBERS' RIGHTS AND RESPONSIBILITIES

R9-31-1301. General Provisions

A. The Administration shall administer the program as specified in A.R.S. § 36-2982.

B. The Director has full operational authority to adopt rules or to use the appropriate rules adopted as specified in A.R.S. § 36-2986.

C. This Article defines the notice and appeal process when a contractor reduces, suspends or terminates a service and provides a member with the opportunity for an expedited hearing.

D. For the purpose of this Article:
1. Contractor means a health plan, a qualifying plan, a RBHA or ADHS.
2. Request for hearing means a clear expression by a member or an authorized representative that a member wants the opportunity to present the member's case to a reviewing authority.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1302. Denial of a Request for a Service

A contractor shall provide a member with a written notice no later than 3 business days from the date when authorization for a requested service is denied by the party giving notice.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1303. Reduction, Suspension, or Termination of a Service

Except as permitted under R9-31-1305 and R9-31-1306, a contractor shall provide a member with a written Notice of Intended Action at least 10 days prior to the date of the action by a contractor when there is a reduction, suspension, or termination of a service currently provided by a contractor.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1304. Content of Notice

A notice, required under R9-31-1302 or R9-31-1303 of this Article, shall contain the following:
1. A statement of what action a contractor intends to take;
2. The succinct and specific reasons for the intended action;
3. The specific law or rule that supports the action, or a change in federal or state law that requires an action;
4. An explanation of:

a. A member's right to request an evidentiary hearing; and
b. The circumstances under which the Administration or a contractor shall grant a hearing in cases of an action based on a change in the law;

5. An explanation of the circumstance under which a contractor shall continue a covered service if a member requests a hearing to appeal an action for a:
   a. Reduction,
   b. Suspension, or
   c. Termination of a service.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1305. Exceptions from an Advance Notice

A contractor may mail a notice of a reduction, suspension, or termination of a service not later than the date of action if a contractor:

1. Has factual information that confirms the death of a member,
2. Receives a clear written statement signed by the member that:
   a. Services are no longer wanted, or
   b. Provides information which requires a reduction or termination of a service and indicates that a member understands that a reduction or termination of a service shall be the result of providing that information,
3. Learns that a member has been admitted to an institution which makes a member ineligible for further services,
4. Does not know a member's whereabouts and the post office returns mail directed to a member indicating no forwarding address,
5. Has established a fact that a member has been accepted for Title XXI services outside the state of Arizona, or
6. Knows that a member's primary care provider has prescribed a change in the level of medical care.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1306. Notice in a Case of Probable Fraud

A contractor may shorten the period of advance notice to 5 days before the date of action if:

1. The facts indicate that action should be taken because of probable fraud by a member; and
2. The facts have been verified through secondary resources, if possible.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1307. Expedited Hearing Process

A. Alternative hearing process. This Section provides an alternative expedited hearing process for denials defined in R9-31-113 and an alternative expedited hearing process and continued services for actions defined in R9-31-113. Except as stated in this Section, the provisions of 9 A.A.C. 31, Article 8 do not apply. If the Administration determines that a request for hearing filed according to this Section was not timely or not a proper appeal of a denial or action as defined in R9-31-113, the request for hearing shall instead be considered a grievance according to 9 A.A.C. 31, Article 8 and, if appropriate, forwarded to the contractor for processing according to 9 A.A.C. 31, Article 8. In this event, services shall not be continued as provided in this Section. If a member does not seek continued services or an expedited hearing, a member may file a grievance according to 9 A.A.C. 31, Article 8. A member shall not receive continued behavioral health services on appeal beyond the statutory limitation on such services.

B. Time-frames. If a contractor determines to deny a service that requires authorization or determines to reduce, suspend, or terminate existing services; and a member desires to appeal the determination and either requests continued services during the hearing process or requests an expedited hearing of a denial for authorization, a member must file a request for hearing:

1. No later than 10 business days from the date of personal delivery of the Notice of Intended Action to the member; or
2. No later than 15 business days from the postmark date, if mailed, of the Notice of Intended Action.

C. Expedited hearing. A hearing according to this Section shall be held no sooner than 20 days and not later than 40 days from the Administration's receipt of the request for hearing. Alternatively, the hearing may be held sooner than 20 days upon the agreement of all of the parties or upon a written motion of 1 of the parties establishing, in the discretion of the Administration, extraordinary circumstances or the possibility of irreparable harm if the hearing is not held sooner.

D. Notice of hearing date. The Administration shall provide notice of the hearing date to the member or the authorized representative and to all other parties to the appeal.

E. Responsibilities of a contractor. A contractor shall provide the current level of an existing service during the expedited hearing process, if a request for hearing and request to continue services are properly filed according to this Section.

F. Previously authorized service. If a member's primary care provider orders a service that has been previously authorized for a member, a contractor may issue a written denial according to R9-31-1302, if a contractor considers the request new and independent of any previous authorization. If a member's primary care provider asserts that the requested service or treatment is merely a necessary continuation of the previous authorization, and a member challenges the denial on this basis, then the service will be continued pending appeal, unless the parties reach some other agreement a contractor believes the primary care provider's request endangers the member. A contractor and a provider shall reserve any dispute over reimbursement until a later date when a provider submits a claim.

G. Responsibility of a member. A member whose service is continued during the expedited hearing process is financially liable for the service received if the Director upholds the decision to reduce, suspend, or terminate a member's service.

H. General provisions. The expedited hearing process shall be conducted according to A.A.C. R9-22-801(A),(E),(G), and (M).

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1308. Maintenance of Records

The party providing notice shall ensure that written records are maintained, that written notification was given to the member, including the date the notification was provided.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Ses-

sion, effective October 23, 1998 (Supp. 98-4).

R9-31-1309. Member Handbook

A contractor shall furnish each member with a handbook that clearly explains a member's right to file a grievance or appeal concerning a denial or action that affects a member's receipt of medical services, as specified in contract.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

ARTICLE 14. RESERVED

ARTICLE 15. RESERVED

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

R9-31-1601. General Requirements

A. R9-31-1601 through R9-31-1624 apply to the acute care services provided to an enrolled member by IHS, a Tribal Facility, or a referral provider. R9-31-1618 through R9-31-1622 and R9-31-1625 apply to behavioral health services provided by the IHS, a Tribal Facility, RBHA or TRBHA.

B. As specified in A.R.S. § 36-2982, the Administration shall administer the program subject to the limitations on funding specified in A.R.S. § 36-2985.

C. As specified in A.R.S. § 36-2986, the Director has full operational authority to adopt rules or to use the appropriate rules adopted for this Article.

D. A Native American who is eligible for Title XXI may receive covered acute care services specified in this Article from:
1. An IHS Area Office as specified in A.R.S. § 36-2982 which has a signed IGA with the Administration,
2. A Tribal Facility as specified in A.R.S. § 36-2982,
3. A contractor which includes a health plan or a qualifying plan as defined in A.R.S. § 36-2981, or
4. A qualifying health center as specified in A.R.S. § 36-2907.06.

E. The IHS and a Tribal Facility shall comply with:
1. Federal and state law;
2. The IGA, if applicable; and
3. The appropriate rules as specified in this Chapter.

F. An individual or an entity that provides covered services for the IHS or a Tribal Facility shall be a registered provider who meets the appropriate certification standards established by the Administration. A provider shall be responsible for:
1. Supervising, coordinating, and providing initial and primary care to the member;
2. Initiating referrals for specialty care;
3. Maintaining continuity of member care; and
4. Maintaining an individual medical record for each assigned member.

G. The IHS and a Tribal Facility shall maintain medical records that:
1. Conform to professional medical standards and practices for documentation of medical, diagnostic and treatment data;
2. Include a detailed record of:
   a. All medically necessary services provided to a member by the IHS or a Tribal Facility,
   b. All emergency services provided by a provider or a nonprovider for a member enrolled with the IHS or receiving services from a Tribal Facility, and
3. Facilitate follow-up treatment.

H. As specified in A.R.S. §§ 36-2986 and 36-2992, the IHS or a Tribal Facility shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1602. General Requirements for Scope of Services

A. In addition to the requirements and the limitations specified in this Chapter, the following general requirements apply:
1. As specified in A.R.S. § 36-2989 and R9-31-1625, covered services provided to a member shall be medically necessary and provided by, or under the direction of, the IHS, a Tribal Facility, a provider, or a dentist. Specialist services shall be provided under referral from the IHS or a Tribal Facility provider.
2. If the IHS can not provide a covered service due to the circumstances delineated in the signed Settlement Agreement CV-86-1105-PHX-RGS, a member shall be referred to a non-IHS provider or a non-IHS facility for the service and a referral form shall be completed and referred to the Administration based on procedures established by the Administration.
3. Experimental services as determined by the Director, or services provided primarily for the purpose of research, shall not be covered;
4. Services or items, if furnished gratuitously, are not covered and payment shall be denied;
5. Personal care items are not covered and payment shall be denied; and
6. Services shall not be covered if provided to:
   a. An inmate of a public institution,
   b. A person who is a resident of an institution for the treatment of tuberculosis,
   c. A person who is in an institution for the treatment of mental diseases at the time of application or at the time of redetermination, or
   d. A person prior to the date of eligibility.

B. Services shall be provided by AHCCCS registered personnel or facilities which are appropriately licensed or certified to provide the services.

C. Payment for services or items requiring prior authorization as defined in this Article may be denied if prior authorization from the Administration is not obtained. Emergency services do not require prior authorization.
1. Services for unrelated conditions, requiring additional diagnostic and treatment procedures, require additional prior authorization.
2. Written documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.

D. As specified in A.R.S. § 36-2989, covered services rendered to a member shall be provided within the service area of the IHS or a Tribal Facility except when:
1. An IHS or a Tribal Facility refers a member out of the area for medical specialty care or behavioral health services,
2. A covered service that is medically necessary for a member is not available within the service area,
3. A member is placed in a nursing facility located out of the service area.

E. If a member requests the provision of a service that is not covered by the program or not authorized by the IHS or a Tribal Facility, the service may be rendered to a member by an AHCCCS-registered service provider under the following conditions:
1. A document lists the requested services and the itemized cost of each is prepared by a provider or a nonprovider and provided to a member, and

2. The signature of a member is obtained in advance of service provision indicating that the services have been explained to a member and that a member accepts responsibility for payment.

F. Noncovered services provided to a member by the IHS, a Tribal Facility or under referral may be paid by the IHS or a Tribal Facility, but not with Title XXI funds.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1603. Inpatient General Hospital Services

A. Inpatient services provided in a general hospital may include:
1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
   a. Maternity care,
   b. Neonatal intensive care (NICU),
   c. Intensive care (ICU),
   d. Surgery,
   e. Nursery,
   f. Routine care, and
   g. Behavioral health (psychiatric) care as specified in A.R.S. § 36-2989 and 9 A.A.C. 31, Article 12.
2. Ancillary services as specified by the Director:
   a. Labor, delivery and recovery rooms, and birthing centers;
   b. Surgery and recovery rooms;
   c. Laboratory services;
   d. Radiological and medical imaging services;
   e. Anesthesiology services;
   f. Rehabilitation services;
   g. Pharmaceutical services and prescribed drugs;
   h. Respiratory therapy;
   i. Blood and blood derivatives;
   j. Central supply items, appliances, and equipment not ordinarily furnished to all patients and which are customarily reimbursed as ancillary services;
   k. Maternity services; and
   l. Nursery and related services.

B. The following limitations apply to general inpatient hospital services that are provided by a fee-for-service provider and for which the Administration is financially responsible:
1. The cost of an inpatient hospital accommodation for a member shall be incorporated into the rate paid for the level of care in subsection (A)(1).
2. Prior authorization shall be obtained from the Administration for a member referred out of the IHS or a Tribal Facility for the following inpatient hospital services provided to a member:
   a. Non-emergency and elective admission, prior to the scheduled admission;
   b. Elective surgery prior to the surgery;
   c. An emergency hospitalization that exceeds 3 days or an intensive care unit admission that exceeds 1 day;
   d. Hospitalization beyond the number of days initially authorized shall be covered only if determined medically necessary through the Administration's concurrent team review; or
   e. A service or an item furnished to cosmetically reconstruct appearance after the on-set of trauma or serious injury shall be authorized prior to service delivery.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1604. Physician and Primary Care Physician and Practitioner Services

A. Primary care services shall be furnished by a physician or a primary care practitioner. Primary care services may be provided in an inpatient or outpatient setting and shall include:
1. Periodic health examinations and assessments,
2. Evaluations and diagnostic workups,
3. Prescriptions for medications and medically necessary supplies and equipment,
5. Referrals to a specialist or other health care professional when medically necessary as specified in A.R.S. § 36-2989,
6. Patient education,
7. Home visits when determined medically necessary,
8. Covered immunizations, and
9. Covered preventive health services.

B. As specified in A.R.S. § 36-2989, a 2nd opinion procedure may be required to determine coverage for surgeries for a member referred out of the IHS or a Tribal Facility. Under this procedure, documentation must be provided by at least 2 physicians as to the need for the proposed surgery.

C. The following limitations and exclusions apply to physician and practitioner services and primary care provider services for a member referred out of the IHS or a Tribal Facility:
1. Specialty care and other services provided to a member upon referral from a primary care provider shall be limited to the services or conditions for which the referral is made, or for which authorization is given;
2. If a physical examination is performed with the primary intent to accomplish 1 or more of the objectives listed in subsection (A), it may be covered by the IHS or a Tribal Facility except if there is an additional or alternative objective to satisfy the demands of an outside public or private agency. Alternative objectives may include physical examinations and resulting documentation for:
   a. Qualification for insurance,
   b. Pre-employment physical evaluation,
   c. Qualification for sports or physical exercise activities,
   d. Pilot's examination (FAA),
   e. Disability certification for establishing any kind of periodic payments,
   f. Evaluation for establishing 3rd-party liabilities, or
   g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection (A).
3. The following services shall be excluded from Title XXI coverage:
   a. Infertility services, reversal of surgically induced infertility (sterilization), and sex change operations;
   b. Services or items furnished solely for cosmetic purposes;
   c. Hysterectomies, unless determined to be medically necessary;
   d. Abortion counseling or abortion except according to federal law;
   e. Chiropractic services; and
   f. Licensed midwife service for prenatal care and home births.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1605. Organ and Tissue Transplantation Services

A. The following organ and tissue transplantation services are covered for a member as specified in A.R.S. § 36-2989 if prior authorized by the Administration:
1. Kidney transplantation,
2. Simultaneous Kidney/Pancreas transplant,
3. Cornea transplantation,
4. Heart transplantation,
5. Liver transplantation,
6. Autologous and allogenic bone marrow transplantation,
7. Lung transplantation,
8. Heart-lung transplantation, and
9. Other organ transplantation if the transplantation is required by federal law and if other statutory criteria are met.

B. Immunosuppressant medications, chemotherapy, and other related services provided in an IHS, a Tribal Facility, or by a referral provider do not need to be prior authorized.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1606. Dental Services

Medically necessary dental services shall be provided for children under age 19 as specified in A.R.S. § 36-2989.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1607. Laboratory, Radiology, and Medical Imaging Services

As specified in A.R.S. § 36-2989, laboratory, radiology, and medical imaging services may be covered services if:
1. Prescribed for a member by an IHS, a Tribal Facility care provider or a dentist, or if prescribed by a physician or a practitioner upon referral from the IHS, a Tribal Facility provider or a dentist;
2. Provided in a hospital, a clinic, a physician office, or other health care facility by IHS or a Tribal Facility provider; or
3. Provided by an IHS or a Tribal Facility provider that meets all applicable state and federal license and certification requirements and provides only services that are within the scope of practice stated in a provider's license or certification.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1608. Pharmaceutical Services

A. Pharmaceutical services may be provided by the IHS, a Tribal Facility, or under referral from an IHS or a Tribal Facility provider.

B. As specified in A.R.S. § 36-2989, pharmaceutical services shall be covered if prescribed for a member by the IHS, a Tribal Facility provider or a dentist, or if prescribed by a specialist upon referral from the IHS or a Tribal Facility provider.

C. The following limitations shall apply to pharmaceutical services:
1. A medication personally dispensed by a physician or a dentist is not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
2. A prescription in excess of a 30-day supply or a 100-unit dose is not covered unless:
   a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is more.
   b. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.
   c. A member lives in an area not readily accessible to a pharmacy and the prescription is limited to 100-days or 100-unit dose, whichever is more.
3. A nonprescription medication is not covered unless an appropriate alternative over the counter medication is available and less costly than a prescription medication.
4. A prescription is not covered if filled or refilled in excess of the number specified, or if an initial prescription or refill as dispensed after 1 year from the original prescribed order.
5. Approval by an authorized prescriber is required for all changes in, or additions to, an original prescription. The date of a prescription change is to be clearly indicated and initialed by a dispensing pharmacist.

D. The IHS or a Tribal Facility shall monitor and take necessary actions to ensure that a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being, is provided sufficient services to eliminate any gap in the required pharmaceutical regimen.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1609. Emergency Services

Emergency medical services provided by the IHS, a Tribal Facility, or a referral provider outside the service area shall be provided based on the prudent layperson standard to a member by the IHS or a Tribal Facility provider registered with AHCCCS to provide services as specified in A.R.S. § 36-2989.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1610. Transportation Services

A. Emergency ambulance services.
1. As specified in A.R.S. § 36-2989, emergency ambulance transportation services shall be a covered service for a member. Payment shall be limited to the cost of transporting a member in a ground or air ambulance:
   a. To the nearest appropriate provider or medical facility capable of meeting a member's medical needs, and
   b. When no other means of transportation is both appropriate and available.
2. A ground or an air ambulance transport that originates in response to a 9-1-1 call or other emergency response system shall be reimbursed by the Administration for a member if the medical condition at the time of transport justified a medically necessary ambulance transport. No prior authorization is required for reimbursement of these transports.
3. Determination of whether transport is medically necessary shall be based upon the medical condition of a member at the time of transport.

4. Notification to the Administration of emergency transportation provided is not required but a provider shall submit documentation with the claim which justifies the service.

B. Air ambulance services shall be covered only if:
1. The air ambulance transport is initiated upon the request of an emergency response unit, a law enforcement official, a hospital, a clinic medical staff member, the IHS or a Tribal Facility provider, a physician, or a practitioner;
2. The point of pickup is inaccessible by ground ambulance, or great distances, or other obstacles are involved in getting emergency services to a member or transporting a member to the nearest hospital or other provider with appropriate facilities; and
3. The medical condition of a member requires timely ambulance service and ground ambulance service will not suffice.

C. Medically necessary member transfers provided by an emergency air or a ground transportation provider may be covered when a member receiving inpatient services requires transport to another level of care or requires round trip transport to another facility to obtain necessary specialized diagnostic treatment services if:
1. A member's condition is such that the use of any other method of transportation would be harmful to a member's health, and
2. Services are not available in the facility where a member is a patient.

D. Meals, lodging and escort services.
1. Expenses for meals and lodging for a member while en route to, or returning from, an approved and prior authorized health care service site out of a member's service area shall be a Title XXI covered service.
2. Expenses of an escort, who may be a family household member accompanying a member out of a member's service area shall be covered if the services of an escort are ordered in writing by an IHS or a Tribal Facility provider, an attending physician or a practitioner.
3. Meals, lodging and escort services provided by a provider shall be prior authorized by the Administration.

E. Limitations.
1. Expenses shall be allowed only when a member requires a covered service that is not available in the service area;
2. If a member is admitted to an inpatient facility, expenses for an escort shall be covered only when accompanying a member en route to, and returning from, the inpatient facility; and
3. A salary for an escort shall be covered if an escort is not a part of a member's family household.

F. Non-emergency transportation services are not covered as specified in A.R.S. § 36-2989.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1611. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices

A. As specified in A.R.S. § 36-2989, medical supplies, durable equipment, and orthotic and prosthetic devices shall be covered services if prescribed for a member by the IHS or a Tribal Facility provider or if prescribed by a physician or a practitioner upon referral from the IHS or a Tribal Facility provider unless referral is waived by a contractor.

B. Medical supplies include consumable items covered under Medicare that are provided to a member and that are not reusable.

C. Medical equipment includes any durable item, an appliance, or a piece of equipment that is designed for a medical purpose, is generally reusable by others, and is purchased or rented for a member.

D. Prosthetic and orthotic devices include only those items that are essential for the habilitation or rehabilitation of a member.

E. The following limitations apply:
1. If medical equipment cannot be reasonably obtained from alternative resources at no cost, the medical equipment shall be furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the equipment shall not exceed the cost of the equipment if purchased.
2. Reasonable repair or adjustment of purchased medical equipment shall be covered if necessary to make the equipment serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.
3. Changes in, or additions to, an original order for medical equipment shall be approved by a member's IHS or a Tribal Facility provider or an authorized prescriber and shall be indicated clearly and initialed by a vendor.
4. Rental fees shall terminate:
   a. No later than the end of the month in which the IHS or a Tribal Facility provider or an authorized prescriber certifies that a member no longer needs the medical equipment,
   b. When a member is no longer eligible for Title XXI service, or
   c. When a member is no longer enrolled with the IHS with the exception of transitions of care as specified by the Director.
5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming shall not be covered unless needed to treat a medical condition and provided according to a prescription.
6. First aid supplies shall not be covered unless they are provided according to a prescription.

F. Liability and ownership.
1. Purchased durable medical equipment provided to a member but which is no longer needed may be disposed of as specified in the policy of the IHS or a Tribal Facility.
2. If customized durable medical equipment is purchased for a member, the equipment will remain with the member during times of transition, or upon loss of eligibility.
   a. For purposes of this Section, customized durable medical equipment refers to equipment that has been altered or built to specifications unique to a member's medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.
   b. Customized equipment obtained fraudulently by a member shall be returned for disposal to the Administration.

G. A provider shall obtain prior authorization from the Administration before providing the following services to a member referred out of the IHS or a Tribal Facility:
1. Consumable medical supplies exceeding $50.00 per month.
2. Durable medical equipment, prosthetic or orthotic devices for a member for all rentals if the cost to purchase the equipment or devise exceeds $200.00.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1612. Health Risk Assessment and Screening Services

A. As specified in A.R.S. § 36-2989, the following services shall be covered for a member less than 19 years of age:
1. Screening services, including:
   a. Comprehensive health, behavioral health and developmental histories;
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations according to age and health history; and
   d. Health education, including anticipatory guidance.
2. Vision services as specified in A.R.S. § 36-2989 including:
   a. Treatment for medical conditions of the eye,
   b. 1 eye examination per contract year, and
   c. Provision of 1 pair of prescriptive lenses per contract year.
3. Hearing services, including:
   a. Diagnosis and treatment for defects in hearing,
   b. Testing to determine hearing impairment, and
   c. Provision of hearing aids.

B. All providers of services shall meet the following standards:
1. Provide services by or under the direction of a member's IHS or a Tribal Facility provider or a dentist.
2. Perform tests and examinations in accordance with the Administration's Periodicity Schedule.
   a. Refer a member as necessary for dental diagnosis and treatment, and necessary specialty care;
   b. Refer a member as necessary for behavioral health evaluation and treatment services as specified in this Article.

C. The IHS or a Tribal Facility shall meet the following additional conditions for a member:
1. Provide information to a member and a member's parent or guardian concerning services, and
2. Notify a member and a member's parent or guardian regarding the initiation of screening and subsequent appointments according to the Administration's Periodicity Schedule.

D. A member with special health care needs may be referred to the Children's Rehabilitative Service program.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1613. Other Medical Professional Services

A. The following medical professional services provided to a member by the IHS or a Tribal Facility or for a member referred out of the IHS or a Tribal Facility shall be covered services as specified in A.R.S. § 36-2989 when provided in an inpatient, an outpatient, or an office setting within limitations specified below:
1. Dialysis;
2. Family planning services including medications, supplies, devices, and surgical procedures provided to delay or prevent pregnancy. Family planning services are limited to:
   a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service; and
   b. Natural family planning education or referral.
3. Midwife services provided by a certified nurse practitioner;
4. Podiatry services when ordered by an IHS or a Tribal Facility provider;
5. Respiratory therapy;
6. Ambulatory and outpatient surgery facilities services;
7. Home health services;
8. Private or special duty nursing services when medically necessary and prior authorized;
9. Rehabilitation services including physical therapy, occupational therapy, audiology and speech therapy within limitations in this Article;
10. Total parenteral nutrition services; and
11. Chemotherapy.

B. The Administration shall prior authorize services in subsections (A)(4) through (10) for a member referred out of the IHS or a Tribal Facility.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1614. Nursing Facility Services

A. Nursing facility services including room and board shall be covered for a maximum of 90 days per contract year if the medical condition of a member is such that, if nursing facility services are not provided, hospitalization of an individual would result.

B. Except as otherwise provided in 9 A.A.C. 28, the following services shall be excluded for purpose of separate billing if provided in a nursing facility:
1. Nursing services including but not limited to:
   a. Administration of medication,
   b. Tube feedings,
   c. Personal care services (assistance with bathing and grooming),
   d. Routine testing of vital signs, and
   e. Maintenance of catheters.
2. Basic patient care equipment and sickroom supplies, including, but not limited to:
   a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over the counter remedies;
   b. Bathing and grooming supplies;
   c. Identification devices;
   d. Skin lotions;
   e. Medication cups;
   f. Alcohol wipes, cotton balls, and cotton rolls;
   g. Rubber gloves (non sterile);
   h. Laxatives;
   i. Beds and accessories;
   j. Thermometers;
   k. Ice bags;
   l. Rubber sheeting;
   m. Passive restraints;
   n. Glycerin swabs;
   o. Facial tissue;
   p. Enemas;
   q. Heating pads; and
   r. Diapers.
3. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating;
4. Any services that are included in a nursing facility's room and board charge or services that are required of a nursing

facility to meet federal mandates, state licensure standards, or county certification requirements;
5. Physical therapy; and
6. Assistive devices and durable medical equipment.

C. Each nursing facility admission out of the IHS or a Tribal Facility's service area shall be prior authorized by the Administration.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1615. Eligibility and Enrollment
The eligibility and enrollment provisions specified in 9 A.A.C. 31, Article 3 apply to a Native American who elects to receive services through the IHS or a Tribal Facility.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1616. Standards for Payments
A. The Administration shall bear no liability for providing covered services to or completing a plan of treatment for any member beyond the date of termination of a member's eligibility or enrollment as specified in A.R.S. § 36-2987.

B. The Administration shall make payments to the IHS, a Tribal Facility, or under referral from an IHS or a Tribal Facility provider based on the Administration's capped fee schedule as specified in A.A.C. R9-22-710 for outpatient services.

C. The Administration shall make payments to the IHS or a Tribal Facility based on the all inclusive inpatient rates published in the *Federal Register.*

D. The Administration shall pay inpatient and outpatient hospital services provided by a provider under referral from the IHS or a Tribal Facility provider based on A.R.S. §§ 36-2987, 36-2904, 36-2903.01, A.A.C. R9-22-712 and R9-22-718 as applicable. Discounts and penalties shall be as specified in A.R.S. § 36-2987(C).

E. The Administration shall bear no liability for a subcontract that the IHS or a Tribal Facility executes with other parties for the provision of administrative or management services, medical services, or covered health care services, or for any other purpose. The IHS or a Tribal Facility shall indemnify and hold the Administration harmless from any and all liability arising from the IHS or a Tribal Facility's subcontracts, shall bear all costs of defense of any litigation over the liability, and shall satisfy in full any judgment entered against the Administration in litigation involving the IHS or a Tribal Facility's subcontracts.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1617. Prior Authorization
A provider and a nonprovider shall request prior authorization from the Administration according to this Article. The following inpatient hospital services provided to a member enrolled with the IHS out of the IHS or a Tribal Facility require prior authorization from the Administration:
1. Nonemergency and elective admission, shall be authorized prior to admission;
2. Elective surgery, excluding voluntary sterilization, shall be authorized prior to the surgery;
3. An emergency hospitalization that exceeds 3 days or an intensive care admission that exceeds 1 day;
4. Hospitalization beyond the number of days initially authorized shall be covered only if determined medically necessary through the Administration's concurrent team review; and
5. Services or items furnished to cosmetically reconstruct appearance after the on-set of trauma or serious injury shall be authorized prior to service delivery.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1618. Claims
A. Claims submission to the Administration.
1. The IHS, a Tribal Facility, a TRBHA, or a provider under referral shall ensure that a claim for covered services provided to a member is initially received by the Administration not later than 9 months from the date of service or 9 months from the date of eligibility posting, whichever is later. The Administration shall deny a claim not received within the 9 month period from the date of service or 9 months from the date of eligibility posing, whichever is later. If a claim meets the 9 month limitation, the IHS, a Tribal Facility, a TRBHA, or a provider under referral shall file a clean claim which is received by the Administration not later than 12 months from the date of service or 12 months from the date of eligibility posting, whichever is later.
2. The 9 and 12 month deadlines for an inpatient hospital claim begin on the date of discharge for each claim.

B. Claims processing.
1. If a claim contains erroneous or conflicting information, exceeds parameters, fails to process correctly, does not match the Administration's files, or requires manual review to be resolved, the Administration shall report the claim to a provider with a remittance advice.
2. The Administration shall process a hospital claim in accordance with A.A.C. R9-22-712.

C. Overpayments for Title XXI services. An IHS or a Tribal Facility provider, a nonprovider, or a Tribal Facility, shall notify the Administration if a Title XXI overpayment is made. The Administration shall recoup an overpayment from a future claim cycle, or, at the discretion of the Director, require the IHS or a Tribal Facility provider or a nonprovider, to return the incorrect payment to the Administration.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1619. Hospital Claims Review
The IHS and a Tribal Facility shall follow the procedures for a hospital claims review as specified in A.A.C. R9-22-717.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1620. Prohibitions Against Charges to Members
A. The IHS or a Tribal Facility or other provider of care or services shall not charge, submit a claim, demand, or otherwise collect payment from a member or a person acting on behalf of a member for any covered service except to collect an authorized copayment or payment for additional services. The

Administration shall have the right to recover from a member that portion of payment made by a 3rd-party to a member when the payment duplicates Title XXI paid benefits and has not been assigned to the IHS or a Tribal Facility. The IHS or a Tribal Facility who makes a claim under this provision shall not charge more than the actual, reasonable cost of providing the covered services.

B. An IHS or a Tribal Facility provider shall not bill or make any attempt to collect payment, directly or through a collection agency, from an individual claiming to be Title XXI eligible without 1st receiving verification from the Administration that the individual was ineligible for Title XXI on the date of service or that the services provided were not covered by Title XXI as specified in A.R.S. § 36-2989.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1621. Transfer of Payments

Payments permitted. Payments may be made to other than the IHS, a Tribal Facility, or a referral provider as follows:

1. Payment made in accordance with an assignment to a government agency or an assignment made according to a court order; or
2. Payment made to a business agent, such as a billing service or accounting firm, who renders statements and receives payment in the name of the IHS, a Tribal Facility, or a provider providing that an agent's compensation for this service is:
   a. Reasonably related to the cost of processing the statements, and
   b. Not dependent upon the actual collection of payment.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1622. The Administration's Liability to Hospitals for the Provision of Emergency and Subsequent Care

A. Liability to the Administration for an emergency medical condition of a member who is provided care outside the IHS or a Tribal Facility's service area shall be subject to reimbursement only until a member's condition is stabilized and a member is transferable, or until a member is discharged following stabilization subject to the requirements of A.R.S. § 36-2989.

B. Subject to subsection (A), if a member cannot be transferred following stabilization to the IHS or a Tribal Facility, the Administration shall pay for all appropriately documented, prior authorized, and medically necessary treatment provided to a member before the date of discharge or transfer according to payment standards in R9-31-705.

C. If a member refuses transfer from a nonprovider or a noncontracting hospital to the IHS or a Tribal Facility, the Administration shall not be liable for any costs incurred after the date of refusal if:

1. After consultation with a member's IHS or a Tribal Facility, a member continues to refuse the transfer; and
2. A member has been provided and signs a written statement, before the date of transfer of liability, informing a member of the medical and financial consequences of refusing to transfer. If a member refuses to sign a written statement, a statement signed by 2 witnesses indicating that a member was informed may be substituted.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1623. Copayments

A. The IHS or a Tribal Facility shall be responsible for collecting a $5.00 copayment from a member for non-emergency use of the emergency room.

B. The IHS or a Tribal Facility shall ensure that a member is not denied services because of a member's inability to pay a copayment.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1624. Specialty Contracts

The Director may at any time negotiate or contract for specialized hospital and medical services including, but not limited to, transplants, neonatology, neurology, cardiology, and burn care. Specialty contractors shall take precedence over all other contractual arrangements between the IHS or a Tribal Facility. If the Administration and a hospital perform a transplant surgery on a member that does not have a contracted rate, the system shall not reimburse a hospital more than the contracted rate established by the Administration.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-1625. Behavioral Health Services

A. The IHS, a contractor, a TRBHA, a RBHA or a Tribal Facility may provide any or all of the behavioral health services specified in 9 A.A.C. 31, Article 12, subject to the limitations and specifications stated in 9 A.A.C. 31, Article 12, to a Native American who is eligible for Title XXI services.

B. It is the responsibility of the IHS, a Tribal Facility, a contractor, a TRBHA or a RBHA to monitor the limitations and specifications prescribed in 9 A.A.C. 31, Article 12. Services provided in excess of the limitations and specifications prescribed in 9 A.A.C. 31, Article 12 shall not be reimbursed by the Administration.

C. The IHS, a Tribal Facility, a contractor, a TRBHA or a RBHA shall cooperate as specified in contract, IGA, or this Chapter when the transition from 1 entity to another becomes necessary. For a Title XXI member, this transition shall include tracking and reporting of services used by a member toward the annual limitations prior to the transfer of care.

D. The IHS and a Tribal Facility shall be considered a provider for the provision of behavioral health services and shall be subject to the requirements of:

1. A TRBHA if 1 is operating in a service area, or
2. A RBHA in a service area that does not have a TRBHA or a contractor for a Native American member with respect to prior authorization and service authorizations.

E. If either the IHS or a Tribal Facility cannot provide a nonemergency inpatient or an outpatient behavioral health service, the IHS or a Tribal Facility shall determine if a member is:

1. Less than 18 years old or 18 years old and SMI. A member who is less than 18 years old or 18 years old and SMI, shall be referred to either a TRBHA or a RBHA for the provision of all nonemergency behavioral health services.
2. 18 years old and not SMI. For a member who is 18 years old and not SMI, the IHS or a Tribal Facility must determine if a member is enrolled with a contractor or the IHS.

Depending on the enrollment, a referral shall be done in the following manner for nonemergency behavioral health services:

a. If a member is enrolled with a contractor, the IHS or a Tribal Facility shall refer a member to a contractor for the provision of all nonemergency behavioral health services.
b. If a member is enrolled with IHS, the IHS shall refer a member to an appropriate provider for all nonemergency behavioral health services. A Tribal Facility shall refer a member to IHS and IHS shall refer a member to an appropriate provider.

F. Behavioral health emergency and crisis stabilization services shall be handled as follows:

1. If a member is enrolled with the IHS or a contractor and is not enrolled with a TRBHA or a RBHA, the IHS or a contractor is responsible for the provision of emergency behavioral health services. For an 18 year old, non SMI member, the IHS or a contractor is responsible for all medically necessary treatment subject to the 30 day, 30 visit limitation. For a member under age 18, or an 18 year old SMI member, the IHS or a contractor is responsible for up to 3 days per admission, not to exceed 12 days per contract year, and shall refer a member to a TRBHA or a RBHA.
2. Inpatient service limitations shall apply to emergency or crisis stabilization services provided on an inpatient basis.
3. Emergency or crisis intervention services provided on an outpatient basis by a psychiatrist, a certified psychiatric nurse practitioner, a psychologist, or a qualified facility shall not count towards the outpatient service limitation.

G. Prior authorization must be obtained for all inpatient hospitalizations and partial care services as authorized in R9-31-1202 and R9-31-1203.

H. A provider shall comply with the requirements specified in subsections (B), (C), & (D) or payment may be denied, or if paid, may be recouped by the Administration.

I. A behavioral health service provided by the IHS or a Tribal Facility shall be reimbursed as specified in R9-31-1616.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).