NOTICES OF EXEMPT RULEMAKING

The Administrative Procedure Act requires the *Register* publication of the rules adopted by the state's agencies under an exemption from all or part of the Administrative Procedure Act. Some of these rules are exempted by A.R.S. §§ 41-1005 or 41-1057; other rules are exempted by other statutes; rules of the Corporation Commission are exempt from Attorney General review pursuant to a court decision as determined by the Corporation Commission.

NOTICE OF FINAL EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 20. DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH SERVICE AGENCIES: LICENSURE

PREAMBLE

1. Sections Affected | **Rulemaking Action**

Sections Affected	Rulemaking Action
Article 1	Amend
R9-20-101	Repeal
R9-20-101	New Section
R9-20-102	Repeal
R9-20-102	New Section
R9-20-103	Repeal
R9-20-103	New Section
R9-20-104	Repeal
R9-20-104	New Section
R9-20-105	Repeal
R9-20-105	New Section
Table 1	New Table
R9-20-106	Repeal
R9-20-106	New Section
R9-20-107	Repeal
R9-20-107	New Section
R9-20-108	Repeal
R9-20-108	New Section
R9-20-109	Repeal
R9-20-110	Repeal
R9-20-111	Repeal
R9-20-112	Repeal
R9-20-113	Repeal
R9-20-114	Repeal
Article 2	Repeal
Article 2	New Article
R9-20-201	Repeal
R9-20-201	New Section
R9-20-202	New Section
R9-20-203	New Section
R9-20-204	New Section
R9-20-205	New Section
R9-20-206	New Section
R9-20-207	New Section
R9-20-208	New Section
R9-20-209	New Section
R9-20-210	New Section
R9-20-211	New Section
R9-20-212	New Section

R9-20-213	New Section
R9-20-214	New Section
R9-20-215	New Section
Article 3	Repeal
Article 3	New Article
R9-20-301	Repeal
R9-20-301	New Section
R9-20-302	Repeal
R9-20-302	New Section
R9-20-303	Repeal
R9-20-303	New Section
R9-20-304	Repeal
R9-20-305	Repeal
R9-20-306	Repeal
R9-20-307	Repeal
R9-20-308	Repeal
R9-20-309	Repeal
R9-20-310	Repeal
R9-20-311	Repeal
Article 4	Repeal
Article 4	New Article
R9-20-401	Repeal
R9-20-401	New Section
R9-20-402	Repeal
R9-20-402	New Section
R9-20-403	Repeal
R9-20-403	New Section
R9-20-404	Repeal
R9-20-404	New Section
R9-20-405	Repeal
R9-20-405	New Section
R9-20-406	Repeal
R9-20-406	New Section
R9-20-407	Repeal
R9-20-407	New Section
R9-20-408	Repeal
R9-20-408	New Section
R9-20-409	Repeal
R9-20-409	New Section
R9-20-410	Repeal
R9-20-410	New Section
R9-20-411	Repeal
R9-20-412	Repeal
R9-20-413	Repeal
Article 5	Repeal
Article 5	New Article
R9-20-501	Repeal
R9-20-501	New Section
R9-20-502	Repeal
R9-20-502	New Section
R9-20-503	Repeal
R9-20-503	New Section
R9-20-504	Repeal
R9-20-504	New Section
R9-20-505	Repeal
R9-20-505	New Section
R9-20-506	Repeal
R9-20-506	New Section
Article 6	Repeal

Article 6	New Article
R9-20-601	Repeal
R9-20-601	New Section
R9-20-602	Repeal
R9-20-602	New Section
R9-20-603	Repeal
R9-20-604	Repeal
R9-20-605	Repeal
Article 7	Repeal
Article 7	New Article
R9-20-701	Repeal
R9-20-701	New Section
R9-20-702	Repeal
Article 8	Repeal
Article 8	New Article
R9-20-801	Repeal
R9-20-801	New Section
R9-20-802	Repeal
R9-20-802	New Section
R9-20-803	New Section
Article 9	Repeal
Article 9	New Article
R9-20-901	Repeal
R9-20-901	New Section
R9-20-902	Repeal
R9-20-902	New Section
R9-20-903	Repeal
R9-20-903	New Section
R9-20-904	New Section
Article 10	Repeal
Article 10	New Article
R9-20-1001	Repeal
R9-20-1001	New Section
R9-20-1002	Repeal
R9-20-1002	New Section
R9-20-1003	Repeal
R9-20-1003	New Section
R9-20-1004	New Section
R9-20-1005	New Section
R9-20-1006	New Section
R9-20-1007	New Section
R9-20-1008	New Section
R9-20-1009	New Section
R9-20-1010	New Section
R9-20-1011	New Section
R9-20-1012	New Section
R9-20-1013	New Section
R9-20-1014	New Section
Article 11	Repeal
Article 11	New Article
R9-20-1101	Repeal
R9-20-1101	New Section
R9-20-1102	Repeal
Article 12	Repeal
Article 12	New Article
R9-20-1201	Repeal
R9-20-1201	New Section
R9-20-1202	New Section
Article 13	Repeal

Article 13	New Article
R9-20-1301	Repeal
R9-20-1301	New Section
R9-20-1302	Repeal
R9-20-1303	Repeal
R9-20-1304	Repeal
R9-20-1305	Repeal
R9-20-1306	Repeal
R9-20-1307	Repeal
R9-20-1308	Repeal
R9-20-1309	Repeal
R9-20-1310	Repeal
R9-20-1311	Repeal
R9-20-1312	Repeal
R9-20-1313	Repeal
R9-20-1314	Repeal
Article 14	Repeal
Article 14	New Article
R9-20-1401	Repeal
R9-20-1401	New Section
R9-20-1402	Repeal
R9-20-1403	Repeal
Article 15	New Article
R9-20-1501	New Section
R9-20-1502	New Section
R9-20-1503	New Section
R9-20-1504	New Section
R9-20-1505	New Section
R9-20-1506	New Section
R9-20-1507	New Section
R9-20-1508	New Section
Article 16	Repeal
R9-20-1601	Repeal
R9-20-1602	Repeal
R9-20-1603	Repeal
Article 17	Repeal
R9-20-1701	Repeal
R9-20-1702	Repeal
R9-20-1703	Repeal
R9-20-1704	Repeal
R9-20-1705	Repeal
R9-20-1706	Repeal
R9-20-1707	Repeal
R9-20-1708	Repeal
R9-20-1709	Repeal
R9-20-1710	Repeal
R9-20-1711	Repeal
R9-20-1712	Repeal
R9-20-1713	Repeal
Article 18	Repeal
R9-20-1801	Repeal
R9-20-1802	Repeal
R9-20-1803	Repeal
R9-20-1804	Repeal
R9-20-1805	Repeal
R9-20-1806	Repeal
R9-20-1807	Repeal
R9-20-1808	Repeal
R9-20-1809	Repeal

R9-20-1810	Repeal
R9-20-1811	Repeal
R9-20-1812	Repeal
R9-20-1813	Repeal
R9-20-1814	Repeal
R9-20-1815	Repeal
R9-20-1816	Repeal
R9-20-1817	Repeal
Exhibit A	Repeal
Article 19	Repeal
R9-20-A1901	Repeal
R9-20-A1902	Repeal
R9-20-B1901	Repeal
R9-20-B1902	Repeal
R9-20-B1903	Repeal
R9-20-B1904	Repeal
R9-20-B1905	Repeal
R9-20-B1906	Repeal
R9-20-B1907	Repeal
R9-20-B1908	Repeal
R9-20-B1909	Repeal

2. The specific authority for rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

General Authority: A.R.S. § 36-132(A)(17) and A.R.S. § 36-405(A) and (B)(1)

Specific Authority: A.R.S. § 36-204(1) and (4) through (5), A.R.S. § 36-502(A) through (B), A.R.S. § 36-2003(A)(6), A.R.S. § 36-2003(B)(1) and (3), A.R.S. § 36-2052, A.R.S. § 36-3005(4), A.R.S. § 36-3707(B)(1), A.R.S. § 13-3601.01(A)

3. The effective date of the rule:

October 3, 2001

4. A list of all previous notices appearing in the Register addressing the exempt rule:

Notice of Rulemaking Docket Opening: 6 A.A.R. 962, March 10, 2000

Notice of Proposed Exempt Rulemaking: 7 A.A.R. 3247, August 3, 2001

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Kathleen Phillips, Rules Administrator

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Fax: (602) 364-1150

or

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or

Name: Johnie Golden, Program Manager

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Fax: (602) 861-0643

6. An explanation of the rule, including the agency's reason for initiating the rule, including the statutory citation to the exemption from the regular rulemaking procedures:

The final exempt rules will replace the existing rules for licensure of behavioral health service agencies in their entirety. The final exempt rules clarify and streamline the standards for behavioral health service agencies and address changes in the delivery of behavioral health services that have occurred in Arizona and across the nation. The final exempt rules add specific requirements for new types of behavioral health service agencies, including agencies that treat sexually violent persons, shelters for victims of domestic violence, and adult therapeutic foster homes, and also add requirements for new types of behavioral health services, including misdemeanor domestic violence offender treatment. The final exempt rules conform to recent federal standards for opioid treatment and the use of restraint or seclusion in psychiatric hospitals and residential treatment centers. The final exempt rules also add time-frames as required by A.R.S. § 41-1073 and conform to current rulemaking format and style requirements.

Laws 2001, Chapter 367 exempts the Department from the regular rulemaking procedures in A.R.S. Title 41, Chapter 6.

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The summary of the economic, small business and consumer impact:

According to Laws 2001, Chapter 367, the Department is exempt from the requirement to complete an economic, small business, and consumer impact statement.

9. A description of the changes between the proposed rules, including supplemental notices and the final rules (if applicable):

Not applicable

10. A summary of the principal comments and the agency response to them:

Not applicable

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

12. Incorporations by reference and their location in the rules:

R9-20-101(45)(a): American Psychiatric Association, DSM-IV: Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994)

R9-20-101(45)(b): National Center for Health Statistics, U.S. Department of Health and Human Services, ICD-9-CM: International Classification of Diseases, 9th Revision, Clinical Modification (5th ed. 2000)

R9-20-211(A)(3)(b)(v): 42 U.S.C. § 290dd-2 (1994 & Supplement V 1999)

R9-20-301(C)(1): "The Food Guide Pyramid" in Center for Nutrition Policy and Promotion, U.S. Department of Agriculture, Home and Garden Bulletin No. 252, The Food Guide Pyramid (rev. 1996)

R9-20-502(A)(2)(a): 42 CFR 456.160 (2000)

R9-20-502(A)(2)(b): 42 CFR 441.102 (2000) or 42 CFR 456.180 through 456.181 (2000)

R9-20-502(A)(2)(c): 42 CFR 456.200 through 456.213 (2000) and 42 CFR 482.30 (2000)

R9-20-502(A)(2)(d): 42 CFR 456.170 through 456.171 (2000)

R9-20-502(A)(2)(e): 42 CFR 456.231 through 456.238 (2000)

R9-20-502(A)(2)(f): 42 CFR 456.241 through 456.245 (2000)

R9-20-502(A)(2)(g): 42 CFR 456, Subpart J (2000)

R9-20-502(A)(2)(h): 42 CFR 482.13(f) (2000)

R9-20-502(A)(2)(i): 42 CFR 482.61 and 482.62 (2000)

R9-20-502(A)(3)(a): 42 CFR 441.150 and 441.152 through 441.156 (2000)

R9-20-502(A)(3)(b): 42 CFR 441.151, as published in 66 FR 7148 (2001) and amended in 66 FR 15800 (2001)

R9-20-505(A)(5): 42 CFR Part 483, Subpart G, as published in 66 FR 7148 (2001) and amended in 66 FR 15800 (2001) and 66 FR 28110 (2001)

R9-20-1003(C)(1)(a): U.S. Food and Drug Administration, U.S. Department of Health and Human Services, Form FDA 2635, Consent to Treatment With an Approved Narcotic Drug (July 1993)

R9-20-1003(C)(1)(b): U.S. Food and Drug Administration, U.S. Department of Health and Human Services, Form FDA 2635a, Consentimiento Para El Tratamiento Con Un Narcotico Aprobado (May 1996)

R9-20-1003(C)(3)(f): 42 CFR Part 2 (2000)

13. Was this rule previously adopted as an emergency rule?

No

14. The full text of the rule follows:

TITLE 9. HEALTH SERVICES

CHAPTER 20. DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH SERVICE AGENCIES: LICENSURE

ARTICLE 1. GENERAL

Section
R9-20-101. Definitions
R9-20-102. ~~Licensure Requirements; Exceptions~~ Agency Subclasses and Required and Authorized Services
R9-20-103. ~~Licensure Procedure~~ Initial License Application
R9-20-104. ~~Initial License~~ License Renewal
R9-20-105. ~~Renewal License~~ Time-frames
Table 1. Time-frames (in days)
R9-20-106. ~~Provisional License~~ Changes Affecting a License
R9-20-107. ~~Inspections~~ Enforcement Actions
R9-20-108. ~~Complaint Investigations~~ Denial, Revocation, or Suspension of a License
R9-20-109. ~~Plan of Correction~~ Repealed
R9-20-110. ~~Department Reports and Records~~ Repealed
R9-20-111. ~~Required Reports~~ Repealed
R9-20-112. ~~Client Fees and Charges~~ Repealed
R9-20-113. ~~Research~~ Repealed
R9-20-114. ~~Grievance Procedure~~ Repealed

ARTICLE 2. ~~CLIENT RIGHTS~~ UNIVERSAL RULES

Section
R9-20-201. ~~Client Rights~~ Administration
R9-20-202. Required Reports
R9-20-203. Client Rights
R9-20-204. Staff Member and Employee Qualifications and Records
R9-20-205. Clinical Supervision
R9-20-206. Orientation and Training
R9-20-207. Staffing Requirements
R9-20-208. Admission Requirements
R9-20-209. Assessment and Treatment Plan
R9-20-210. Discharge
R9-20-211. Client Records
R9-20-212. Transportation
R9-20-213. Outings
R9-20-214. Environmental Standards
R9-20-215. Time Out and Emergency Safety Response

ARTICLE 3. ~~AGENCY ADMINISTRATION~~ OUTPATIENT CLINIC REQUIREMENTS

Section
R9-20-301. ~~General Agency Administration~~ Universal Outpatient Clinic Requirements
R9-20-302. ~~Administrator~~ Supplemental Requirements for Counseling
R9-20-303. ~~Clinical or Program Director~~ Supplemental Requirements for Medication Services
R9-20-304. ~~General Personnel Requirements~~ Repealed
R9-20-305. ~~Notice of Conviction; Fingerprinting of Staff Members Providing Behavioral Health Services Directly to Children or to Clients in Domestic Violence Shelters~~ Repealed
R9-20-306. ~~Personnel Qualifications~~ Repealed
R9-20-307. ~~Clinical Supervision~~ Repealed
R9-20-308. ~~Staff Development and Training Requirements~~ Repealed
R9-20-309. ~~Personnel Files~~ Repealed
R9-20-310. ~~Staffing Requirements~~ Repealed
R9-20-311. ~~Health and Safety~~ Repealed

ARTICLE 4. ~~CLIENT SERVICE REQUIREMENTS~~ RESIDENTIAL AGENCY REQUIREMENTS

Section
R9-20-401. ~~Admission and Discharge Criteria~~ Supplemental Admission Requirements
R9-20-402. ~~Client Assessment~~ Supplemental Requirements for Social, Recreational, or Rehabilitative Activities
R9-20-403. ~~Staffing Requirements for Assessment Services~~ Supplemental Requirements for Client Funds
R9-20-404. ~~Treatment of Services Planning~~ Supplemental Requirements for an Agency that Provides Behavioral Health Services to Children
R9-20-405. ~~Requirements for Client Recordkeeping~~ Environmental Standards
R9-20-406. ~~Client Records for Non-emergency Services~~ Fire Safety Standards
R9-20-407. ~~Client Record Requirements for Emergency Services~~ Food Service Requirements
R9-20-408. ~~Medication Control~~ Assistance in the Self-Administration of Medication
R9-20-409. ~~Initial Emergency Care~~ Supplemental Requirements for a Level 2 Behavioral Health Residential Agency
R9-20-410. ~~Supplemental Requirements for Agencies Providing Services to Children~~ Supplemental Requirements for a Level 3 Behavioral Health Residential Agency
R9-20-411. ~~Food Services~~ Repealed
R9-20-412. ~~Pets and Domestic Animals~~ Repealed
R9-20-413. ~~Outings and Transportation~~ Repealed

ARTICLE 5. ~~ENVIRONMENT; PHYSICAL PLANT; SWIMMING POOLS~~ INPATIENT TREATMENT PROGRAM REQUIREMENTS

Section
R9-20-501. ~~Agency Environment~~ Universal Inpatient Treatment Program Requirements
R9-20-502. ~~Indoor Environmental Requirements for Level I, II, and III Behavioral Health Facilities~~ Supplemental Requirements for a Level 1 Psychiatric Acute Hospital
R9-20-503. ~~Environmental Cleanliness and Sanitation for Level I, II, and III Behavioral Health Facilities~~ Supplemental Requirements for Crisis Services
R9-20-504. ~~Supplemental Requirements for Outdoor Areas of Level I, II, and III Behavioral Health Facilities~~ Supplemental Requirements for Detoxification Services
R9-20-505. ~~Physical Plant Standards~~ Supplemental Requirements for a Level 1 RTC
R9-20-506. ~~Swimming Pools in Ground or Permanently Installed~~ Supplemental Requirements for a Level 1 Sub-Acute Agency

ARTICLE 6. ~~LEVEL I BEHAVIORAL HEALTH SERVICE AGENCIES~~ USE OF RESTRAINT OR SECLUSION

Section
R9-20-601. ~~Level I General Licensure Requirements~~ Definitions
R9-20-602. ~~Level I Behavioral Health Facilities Providing Detoxification Services~~ Requirements for Use of Restraint or Seclusion
R9-20-603. ~~Level I Behavioral Health Facilities Providing Restrictive Behavior Management~~ Repealed
R9-20-604. ~~Level I Behavioral Health Facilities Providing Psychiatric Acute Care~~ Repealed
R9-20-605. ~~Level I Behavioral Health Facilities Providing Intensive Treatment~~ Services Repealed

ARTICLE 7. ~~LEVEL II BEHAVIORAL HEALTH SERVICE AGENCIES~~ LEVEL 1 SPECIALIZED TRANSITIONAL AGENCY

Section
R9-20-701. ~~Level II General Licensure Requirements~~ Supplemental Requirements for a Level 1 Specialized Transitional Agency
R9-20-702. ~~Level II Behavioral Health Facilities Providing Structured Services~~ Repealed

ARTICLE 8. ~~LEVEL III BEHAVIORAL HEALTH SERVICE AGENCIES~~ COURT-ORDERED SERVICES

Section
R9-20-801. ~~Level III General Licensure Requirements~~ Supplemental Requirements for Pre-Petition Screening
R9-20-802. ~~Level III Behavioral Health Facilities Providing Supervised Services~~ Supplemental Requirements for Court-Ordered Evaluation
R9-20-803. Supplemental Requirements for Court-Ordered Treatment

ARTICLE 9. ~~EMERGENCY/CRISIS BEHAVIORAL HEALTH SERVICES~~ DUI

Section
R9-20-901. ~~General Licensure Requirements for Emergency/Crisis Behavioral Health Services~~ Exceptions for a Licensee of an Agency That Only Provides DUI Screening or DUI Education or Both
R9-20-902. ~~Emergency/Crisis Behavioral Health Services~~ Supplemental Requirements for DUI Screening
R9-20-903. ~~Mobile Crisis Services~~ Supplemental Requirements for DUI Education
R9-20-904. Supplemental Requirements for DUI Treatment

ARTICLE 10. ~~OUTPATIENT SERVICES~~ OPIOID TREATMENT

Section
R9-20-1001. ~~Outpatient Clinic~~ Definitions
R9-20-1002. ~~Outpatient Rehabilitation~~ Administration
R9-20-1003. ~~Outpatient Detoxification Services~~ Admission
R9-20-1004. Assessment and Treatment Plan
R9-20-1005. Dosage
R9-20-1006. Drug Screening
R9-20-1007. Take-Home Medication
R9-20-1008. Detoxification Treatment
R9-20-1009. Counseling and Medical Services
R9-20-1010. Diverse Populations
R9-20-1011. Preparedness Planning
R9-20-1012. Client Records
R9-20-1013. Community Relations
R9-20-1014. Diversion Control

ARTICLE 11. ~~BEHAVIORAL HEALTH CASE MANAGEMENT AGENCY~~ MISDEMEANOR DOMESTIC VIOLENCE OFFENDER TREATMENT

Section
R9-20-1101. ~~Behavioral Health Case Management Agency~~ Misdemeanor Domestic Violence Offender Treatment Standards
R9-20-1102. ~~Service Requirements~~ Service Requirements for Case management Agencies Repealed

ARTICLE 12. ~~ASSESSMENT, EVALUATION AND DIAGNOSIS SERVICE AGENCIES~~ LEVEL 4 TRANSITIONAL AGENCY

R9-20-1201. ~~Assessment, Evaluation and Diagnosis Service Agency~~ Definitions
R9-20-1202. Standards for a Level 4 Transitional Agency

ARTICLE 13. ~~SHELTERS; HALFWAY HOUSES~~ SHELTER FOR VICTIMS OF DOMESTIC VIOLENCE

R9-20-1301. ~~Shelters; Shelter Services~~ Standards for a Shelter for Victims of Domestic Violence
R9-20-1302. ~~Manager Qualifications and Responsibilities~~ Repealed
R9-20-1303. ~~Staffing Requirements~~ Repealed
R9-20-1304. ~~Residency Requirements~~ Repealed
R9-20-1305. ~~Environmental Standards~~ Repealed
R9-20-1306. ~~Required Recordkeeping~~ Repealed
R9-20-1307. ~~Fire and Safety~~ Repealed

R9-20-1308. ~~Halfway Houses; Halfway House Services~~ Repealed
R9-20-1309. ~~Manager Qualifications and Responsibilities~~ Repealed
R9-20-1310. ~~Staffing Requirements~~ Repealed
R9-20-1311. ~~Residency Requirements~~ Repealed
R9-20-1312. ~~Environmental Standards~~ Repealed
R9-20-1313. ~~Required Recordkeeping~~ Repealed
R9-20-1314. ~~Fire and Safety~~ Repealed

ARTICLE 14. ~~PRE-PETITION SCREENING; COURT ORDERED SERVICES~~ RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY

Section
R9-20-1401. ~~Pre-petition Screening~~ Standards for a Rural Substance Abuse Transitional Agency
R9-20-1402. ~~Mental Health Evaluation and Treatment~~ Repealed
R9-20-1403. ~~Court Ordered Alcoholism Treatment Services~~ Repealed

ARTICLE 15. ~~REPEALED~~ ADULT THERAPEUTIC FOSTER HOME

Section
R9-20-1501. Management
R9-20-1502. Licensee Qualifications and Requirements
R9-20-1503. Supervision
R9-20-1504. Admission
R9-20-1505. Assessment and Treatment Plan
R9-20-1506. Client Records
R9-20-1507. Environmental Standards
R9-20-1508. Food Services

ARTICLE 16. ~~PARTIAL CARE SERVICES~~ REPEALED

Section
R9-20-1601. ~~Partial Care Licensure Requirements~~ Repealed
R9-20-1602. ~~Basic Partial Care Services~~ Repealed
R9-20-1603. ~~Intensive Partial Care Services~~ Repealed

ARTICLE 17. ~~DUI SERVICE AGENCIES~~ REPEALED

Section
R9-20-1701. ~~Definitions~~ Repealed
R9-20-1702. ~~DUI Service Agency Requirements~~ Repealed
R9-20-1703. ~~Administration~~ Repealed
R9-20-1704. ~~Personnel~~ Repealed
R9-20-1705. ~~Staff Supervision~~ Repealed
R9-20-1706. ~~Staff Development and Training~~ Repealed
R9-20-1707. ~~DUI Screening Services~~ Repealed
R9-20-1708. ~~DUI Client Screening Records~~ Repealed
R9-20-1709. ~~DUI Education Services~~ Repealed
R9-20-1710. ~~DUI Client Education Records~~ Repealed
R9-20-1711. ~~DUI Treatment Agency~~ Repealed
R9-20-1712. ~~DUI Client Treatment Records~~ Repealed
R9-20-1713. ~~Physical Plant Requirements~~ Repealed

ARTICLE 18. ~~METHADONE OR METHADONE-LIKE TREATMENT AGENCIES~~ REPEALED

Section
R9-20-1801. ~~Definitions~~ Repealed
R9-20-1802. ~~Methadone or Methadone-Like Treatment Service Agency Requirements~~ Repealed
R9-20-1803. ~~Administration~~ Repealed
R9-20-1804. ~~Client Records~~ Repealed
Exhibit A. ~~"Consent to Methadone Treatment" Form FDA-2635~~ Repealed
R9-20-1805. ~~Program Approval~~ Repealed
R9-20-1806. ~~Admission and Discharge Criteria~~ Repealed
R9-20-1807. ~~Treatment Planning~~ Repealed
R9-20-1808. ~~Drug Testing~~ Repealed

R9-20-1809. ~~Medical Services~~ Repealed
R9-20-1810. ~~Health Care Professionals~~ Repealed
R9-20-1811. ~~Staff Authorized to Dispense Narcotic Drugs~~ Repealed
R9-20-1812. ~~Administration of Methadone~~ Repealed
R9-20-1813. ~~Take-Home Medication~~ Repealed
R9-20-1814. ~~Take-Home Requirements~~ Repealed
R9-20-1815. ~~Short-Term Detoxification Treatment Requirements~~ Repealed
R9-20-1816. ~~Long-Term Detoxification Treatment Requirements~~ Repealed
R9-20-1817. ~~Hospital Use of Methadone for Detoxification Treatment~~ Repealed

ARTICLE 19. ~~LEVEL II RURAL COUNTY DETOXIFICATION SERVICES PILOT PROGRAM~~ REPEALED

Section
Part A. ~~Pilot Program Requirements~~ Repealed
R9-20-A1901. ~~Definitions~~ Repealed
R9-20-A1902. ~~Level II Rural County Detoxification Services Pilot Program~~ Repealed
Part B. ~~Rural County Program Approval~~ Repealed
R9-20-B1901. ~~Approval Requirements~~ Repealed
R9-20-B1902. ~~Management~~ Repealed
R9-20-B1903. ~~Detoxification Services~~ Repealed
R9-20-B1904. ~~Staffing Requirements~~ Repealed
R9-20-B1905. ~~Program Description~~ Repealed
R9-20-B1906. ~~Facility Physical Plant Standards~~ Repealed
R9-20-B1907. ~~Recordkeeping~~ Repealed
R9-20-B1908. ~~Fire and Safety~~ Repealed
R9-20-B1909. ~~Transfer to Another Classification~~ Repealed

ARTICLE 1. GENERAL

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 psychokinetic 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.~~

The following definitions apply in this Chapter unless otherwise specified:

1. "Abuse" means:
    a. For an adult:
        i. The intentional infliction of physical harm or allowing another individual to inflict physical harm;
        ii. Causing injury by negligent acts or omissions;
        iii. Unreasonable or unlawful confinement;
        iv. Sexual abuse, sexual assault, sexual misconduct, molestation, incest or prostitution;
        v. A pattern of ridiculing or demeaning, making derogatory remarks to, verbally harassing, or threatening to inflict physical harm on a client; or
        vi. Pharmacological abuse; or
    b. For a child:
        i. The infliction of, or allowing another individual to inflict, physical harm;
        ii. Causing injury or impairment of bodily functions by negligent acts or omissions;
        iii. A pattern of ridiculing or demeaning, making derogatory remarks to, verbally harassing, or threatening to inflict physical harm on a client;
        iv. Inflicting or allowing another to inflict sexual misconduct, sexual assault, molestation of a child, commercial sexual exploitation of a minor, incest, or child prostitution; or
        v. Pharmacological abuse.
2. "Administrative office" means a designated area in a building used for operating an agency that is at a separate location from the agency's premises.
3. "Administrator" means an individual designated according to R9-20-201(A)(5).
4. "Admission" means the written acceptance by an agency to provide behavioral health services to an individual.
5. "Adult" means an individual 18 years of age or older.
6. "Adult therapeutic foster home" or "sponsor" means an agency that provides behavioral health services and ancillary services to at least one and no more than three adults and where the clients live in the home with, and are integrated into the family of, the individuals providing behavioral health services to the clients.
7. "Agency" means a behavioral health service agency, a classification of a health care institution, including a mental health treatment agency defined in A.R.S. § 36-501, that is licensed to provide behavioral health services according to A.R.S. Title 36, Chapter 4.
8. "Agent" means an adult who has been designated to act for a client who is an adult in a mental health care power of attorney completed by the client according to A.R.S. Title 36, Chapter 32, Article 6.
9. "Ancillary services" means items or activities that are not behavioral health services but are necessary to ensure a client's health, safety, and welfare, such as food, housing, laundry, or transportation.
10. "Assessment" means the collection and analysis of an individual's information required in R9-20-209 to determine the individual's treatment needs.
11. "Assistance in the self-administration of medication" means aid provided to a client in:

a. Storing the client's medication;
b. Reminding the client to take a medication;
c. Verifying that the medication is taken as directed by the client's medical practitioner by:
   i. Confirming that a medication is being taken by the client for whom it is prescribed,
   ii. Checking the dosage against the label on the container, and
   iii. Confirming that the client is taking the medication as directed;
d. Opening a medication container; or
e Observing the client while the client removes the medication from the container or takes the medication.

12. "Behavioral health issue" means an individual's condition related to a mental disorder, personality disorder, substance abuse, or a significant psychological or behavioral response to an identifiable stressor or stressors.
13. "Behavioral health medical practitioner" means an individual licensed and authorized by law to use and prescribe medication and devices, as defined in A.R.S. § 32-1901, and who is one of the following with at least one year of full-time behavioral health work experience:
    a. A physician;
    b. A physician assistant; or
    c. A nurse practitioner.
14. "Behavioral health paraprofessional" means an individual who meets the applicable requirements in R9-20-204 and has:
    a. An associate's degree,
    b. A high school diploma, or
    c. A high school equivalency diploma.
15. "Behavioral health professional" means an individual who meets the applicable requirements in R9-20-204 and is a:
    a. Psychiatrist,
    b. Behavioral health medical practitioner,
    c. Psychologist,
    d. Social worker,
    e. Counselor,
    f. Marriage and family therapist,
    g. Substance abuse counselor, or
    h. Registered nurse with at least one year of full-time behavioral health work experience.
16. "Behavioral health service" means the assessment, diagnosis, or treatment of an individual's behavioral health issue.
17. "Behavioral health technician" means an individual who meets the applicable requirements in R9-20-204 and:
    a. Has a master's degree or bachelor's degree in a field related to behavioral health;
    b. Is a registered nurse;
    c. Is a physician assistant who is not working as a medical practitioner;
    d. Has a bachelor's degree and at least one year of full-time behavioral health work experience;
    e. Has an associate's degree and at least two years of full-time behavioral health work experience;
    f. Has a high school diploma or high school equivalency diploma and a combination of education in a field related to behavioral health and full-time behavioral health work experience totaling at least two years;
    g. Is licensed as a practical nurse, according to A.R.S. Title 32, Chapter 15, with at least three years of full-time behavioral health work experience; or
    h. Has a high school diploma or high school equivalency diploma and at least four years of full-time behavioral health work experience.
18. "Behavioral health work experience" means providing behavioral health services:
    a. In an agency;
    b. To an individual; or
    c. In a field related to behavioral health.
19. "Branch office" means an agency's secondary facility that is open and functioning 20 or fewer hours each week and that provides counseling.
20. "Child" means an individual younger than 18 years of age.
21. "Client" means an individual who is accepted by the agency for the provision of behavioral health services.
22. "Client record" means the collected documentation of the behavioral health services provided to and the information gathered regarding a client, maintained as required in R9-20-211 or as otherwise provided in this Chapter.
23. "Clinical director" means an individual designated by the licensee according to R9-20-201(A)(6).
24. "Clinical supervision" means review of skills and knowledge and guidance in improving or developing skills and knowledge.
25. "Communicable disease" has the same meaning as in A.A.C. R9-6-101.

26. "Conspicuously posted" means displayed in a facility at a location that is accessible and visible to a client and the public.
27. "Contiguous grounds" means real property that can be enclosed by a single unbroken boundary line that does not enclose property owned or leased by another.
28. "Co-occurring disorder" means a combination of a mental disorder or a personality disorder and one or more of the following:
    a. Substance abuse; or
    b. A developmental disability.
29. "Counseling" means the therapeutic interaction between a client, clients, or a client's family and a behavioral health professional or behavioral health technician intended to improve, eliminate, or manage one or more of a client's behavioral health issues and includes:
    a. Individual counseling provided to a client;
    b. Group counseling provided to more than one client or more than one family; or
    c. Family counseling provided to a client or the client's family.
30. "Counselor" means:
    a. An individual who is certified as an associate counselor or a professional counselor according to A.R.S. Title 32, Chapter 33, Article 6;
    b. Until October 3, 2003, an individual who is certified by the National Board of Certified Counselors; or
    c. An individual who is licensed or certified to provide counseling by a government entity in another state if the individual:
        i. Has documentation of submission of an application for certification as a professional counselor or associate counselor according to A.R.S. Title 32, Chapter 33, Article 6; and
        ii. Is certified as a professional counselor or associate counselor according to A.R.S. Title 32, Chapter 33, Article 6 within two years after submitting the application.
31. "Court-ordered alcohol treatment" means detoxification services or treatment provided according to A.R.S. Title 36, Chapter 18, Article 2.
32. "Court-ordered alcohol treatment evaluation" has the same meaning as "evaluation" in A.R.S. § 36-2021.
33. "Court-ordered evaluation" or "evaluation" has the same meaning as "evaluation" in A.R.S. § 36-501.
34. "Court-ordered treatment" means treatment provided according to A.R.S. Title 36, Chapter 5.
35. "CPR" means cardiopulmonary resuscitation.
36. "Crisis services" means immediate and unscheduled behavioral health services provided:
    a. In response to an individual's behavioral health issue to prevent imminent harm or to stabilize or resolve an acute behavioral health issue; and
    b. At a Level 1 psychiatric acute hospital or a Level 1 sub-acute agency.
37. "Current" means up-to-date, extending to the present time.
38. "Custodian" means a person, other than a parent or legal guardian, who stands in loco parentis to the child or a person to whom legal custody of the child has been given by order of the juvenile court.
39. "Danger to others" means that the judgement of a person who has a mental disorder is so impaired that he is unable to understand his need for treatment and as a result of his mental disorder his continued behavior can reasonably be expected, on the basis of a competent medical opinion, to result in serious physical harm.
40. "Danger to self" means:
    a. Behavior which, as a result of a mental disorder, constitutes a danger of inflicting serious physical harm upon oneself, including attempted suicide or the serious threat thereof, if the threat is such that, when considered in the light of its context and in light of the individual's previous acts, it is substantially supportive of an expectation that the threat will be carried out.
    b. Behavior which, as a result of a mental disorder, will, without hospitalization, result in serious physical harm or serious illness to the person, except that this definition shall not include behavior which establishes only the condition of gravely disabled.
41. "Day" means calendar day.
42. "Department" means the department of health services.
43. "Designated representative" means an individual identified in writing by a client or the client's parent, guardian, or custodian to assist the client in protecting the client's rights.
44. "Detoxification services" means behavioral health services and medical services provided:
    a. To reduce or eliminate a client's dependence on, or to provide treatment for a client's signs and symptoms of withdrawal from, alcohol or other drugs; and
    b. At a Level 1 psychiatric acute hospital or a Level 1 sub-acute agency.
45. "Diagnosis" means a determination and labeling of a client's behavioral health issue according to the:
    a. American Psychiatric Association, DSM-IV: Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994), incorporated by reference and on file with the Department and the Office of the Secretary of State and

including no future editions or amendments, available from American Psychiatric Press, Inc., Order Department, 1400 K Street, N.W., Suite 1101, Washington, DC 20005; or
   b. National Center for Health Statistics, U.S. Department of Health and Human Services, ICD-9-CM: International Classification of Diseases, 9th Revision, Clinical Modification (5th ed. 2000), incorporated by reference and on file with the Department and the Office of the Secretary of State and including no future editions or amendments, available from Practice Management Information Corporation, 4727 Wilshire Boulevard, Suite 300, Los Angeles, CA 90010 and from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161.
46. "Discharge" means the written termination of a client's affiliation with an agency, according to R9-20-210.
47. "Discharge summary" means an analysis of the treatment provided to a client and the client's progress in treatment.
48. "Documentation" means written or electronic supportive evidence.
49. "Drug used as a restraint" means a medication that:
   a. Is administered to manage a client's behavior in a way that reduces the safety risk to the client or others,
   b. Has the temporary effect of restricting the client's freedom of movement, and
   c. Is not a standard treatment for the client's medical condition or behavioral health issue.
50. "DSM-IV" means DSM-IV: Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994), incorporated by reference in subsection (45)(a).
51. "DUI client" means an individual who is ordered by the court to receive DUI screening, DUI education, or DUI treatment as a result of an arrest or conviction for a violation of A.R.S. §§ 28-1381, 28-1382, or 28-1383.
52. "DUI education" means a program in which a DUI client participates in at least 16 hours of classroom instruction relating to alcohol or other drugs, as defined in A.R.S. § 28-1301(3).
53. "DUI screening" means a preliminary interview and assessment of a DUI client to determine if the DUI client requires alcohol or other drug education or treatment, as defined in A.R.S. § 28-1301(6).
54. "DUI treatment" means a program that provides at least 20 hours of group counseling in addition to the 16 hours of DUI education, as defined in A.R.S. § 28-1301(7).
55 "Emergency safety response" means physically holding a client, by a trained staff member in an emergency, to safely manage a sudden, intense, or out-of-control client behavior to prevent harm to the client or another individual.
56. "Employee" means an individual who receives compensation from an agency for work performed, but who does not provide behavioral health services.
57. "Exploitation" means the illegal use of a client's resources for another individual's profit or advantage according to A.R.S. Title 46, Chapter 4 or Title 13, Chapter 18, 19, 20, or 21.
58. "Facilities" means buildings used by a health care institution for providing any of the types of services as defined in this chapter.
59. "Family member" means:
   a. A client's parent, step-parent, foster parent, spouse, sibling, child, grandparent, grandchild, aunt, uncle, niece, nephew, or significant other; or
   b. For pre-petition screening, court-ordered evaluation, or court-ordered treatment, the same as defined in A.R.S. § 36-501.
60. "Field related to behavioral health" means an academic discipline or area of study that explores human development, responses, or interactions, such as psychology or sociology.
61. "Full time" means 40 hours a week.
62. "General client supervision" means guidance of a client by a staff member and includes:
   a. Being aware of a client's general whereabouts;
   b. Monitoring a client's activities on the premises or on an agency-sponsored activity off the premises to ensure the health, safety, and welfare of the client; or
   c. Interacting with a client to assist the client in achieving a treatment goal.
63. "Governing authority" means the individual, agency, group or corporation, appointed, elected or otherwise designated, in which the ultimate responsibility and authority for the conduct of the health care institution are vested.
64. "Gravely disabled" means a condition evidenced by behavior in which a person, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because he is unable to provide for his basic physical needs.
65. "Grievance" means a client's documented expression of dissatisfaction to a licensee about an act, omission, or condition of the licensee's agency.
66. "Guardian" means an individual or entity appointed to be responsible for the treatment or care of an individual according to A.R.S. Title 14, Chapter 5 or a similar provision in another state or jurisdiction.
67. "Hazard" means a condition or situation from which a client may suffer physical injury or illness.
68. "High school equivalency diploma" means:

a. The document issued by the Arizona Department of Education under A.R.S. § 15-702 to an individual who passes a general educational development test or meets the requirements of A.R.S. § 15-702(B);
b. The document issued by another state to an individual who passes a general educational development test or meets the requirements of a state statute equivalent to A.R.S. § 15-702(B); or
c. The document issued by another country to an individual who has completed that country's equivalent to a 12th grade education, as determined by the Department.

69. "Immediate" means without delay.
70. "Incident" means an occurrence or event that has the potential to cause harm to a client.
71. "Inpatient treatment program" means a behavioral health service agency that:
    a. Provides medical services and continuous on-site or on-call availability of a behavioral health medical practitioner,
    b. Provides accommodations for a client to stay overnight at the agency, and
    c. May provide restraint or seclusion.
72. "Intern" means an individual who is enrolled in an academic program of a college or university and who provides behavioral health services at an agency as part of the academic program's requirements.
73. "Level 1 psychiatric acute hospital" means an inpatient treatment program that:
    a. Is located in a general hospital, rural general hospital, or special hospital licensed according to 9 A.A.C. 10, unless:
        i. The agency was licensed as a level one psychiatric acute care behavioral health facility before the effective date of this Chapter; and
        ii. The agency does not receive Medicaid funds under Title XIX of the Social Security Act;
    b. Has continuous on-site or on-call availability of a psychiatrist; and
    c. Provides continuous treatment to an individual who is experiencing a behavioral health issue that causes the individual:
        i. To be a danger to self, a danger to others, or gravely disabled; or
        ii. To suffer severe and abnormal mental, emotional, or physical harm that significantly impairs judgment, reason, behavior, or the capacity to recognize reality.
74. "Level 1 residential treatment center" means an inpatient treatment program that provides treatment to an individual under the age of 21 who needs inpatient psychiatric services.
75. "Level 1 RTC" means a Level 1 residential treatment center.
76. "Level 1 specialized transitional agency" means an agency that provides treatment to an individual determined to be a sexually violent person according to A.R.S. Title 36, Chapter 37.
77. "Level 1 sub-acute agency" means an inpatient treatment program that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual:
    a. To have a limited or reduced ability to meet the individual's basic physical and age-appropriate needs;
    b. To be a danger to self, a danger to others, or gravely disabled; or
    c. To suffer severe and abnormal mental, emotional, or physical harm that impairs judgment, reason, behavior, or the capacity to recognize reality.
78. "Level 2 behavioral health residential agency" means a residential agency that provides:
    a. Counseling;
    b. Continuous on-site or on-call availability of a behavioral health professional; and
    c. Continuous treatment to an individual who is experiencing a behavioral health issue that limits the individual's independence but who is able to participate in all aspects of treatment and to meet the individual's basic physical and age-appropriate needs.
79. "Level 3 behavioral health residential agency" means a residential agency that provides continuous protective oversight and treatment to an individual who is able to participate in all aspects of treatment and to meet the individual's basic physical and age-appropriate needs but who needs treatment to maintain or enhance independence.
80. "Level 4 transitional agency" means an agency that provides accommodations where a client receives:
    a. Support to assist the client in managing a crisis situation, or
    b. An opportunity to enhance the client's independent living skills.
81. "Level 4 transitional staff member" means an individual who meets the requirements in R9-20-1202(C) and who provides supportive intervention and general client supervision at a level four transitional agency.
82. "Licensed capacity" means the total number of persons for whom the health care institution is authorized by the Department to provide services as required pursuant to this chapter if the person is expected to stay in the health care institution for more than twenty-four hours. For a hospital, licensed capacity means only those beds specified on the hospital license.
83. "Licensee" means a person authorized by the Department to operate an agency.
84. "Marriage and family therapist" means:

a. An individual who is certified as a marriage and family therapist or associate marriage and family therapist according to A.R.S. Title 32, Chapter 33, Article 7;
b. Until October 3, 2003, an individual who is a clinical member of the American Association of Marriage and Family Therapy; or
c. An individual who is licensed or certified to provide marriage and family therapy by a government entity in another state if the individual:
    i. Has documentation of submission of an application for certification as a marriage and family therapist or associate marriage and family therapist according to A.R.S. Title 32, Chapter 33, Article 7; and
    ii. Is certified as a marriage and family therapist or associate marriage and family therapist according to A.R.S. Title 32, Chapter 33, Article 7 within two years after submitting the application.

85. "Mechanical restraint" means any device, article, or garment attached or adjacent to a client's body that the client cannot easily remove and that restricts the client's freedom of movement or normal access to the client's body but does not include devices used for surgical or orthopedic purposes.
86. "Medical emergency" means a situation that requires immediate medical intervention to prevent death, hospitalization, or serious physical harm.
87. "Medical practitioner" means a:
    a. Physician;
    b. Physician assistant;
    c. Nurse practitioner; or
    d. Other individual licensed and authorized by law to use and prescribe medication and devices, as defined in A.R.S. § 32-1901.
88. "Medical services" means the services pertaining to medical care that are performed at the direction of a physician on behalf of patients by physicians, dentists, nurses and other professional and technical personnel.
89. "Medication" means a prescription medication as defined in A.R.S. § 32-1901 or nonprescription drug, as defined in A.R.S. § 32-1901.
90. "Medication administration" means the provision or application of a medication to the body of a client by a medical practitioner or nurse or as otherwise provided by law.
91. "Medication adjustment" means a change made by a medical practitioner in the medication used to treat a client's behavioral health issue.
92. "Medication monitoring" means the determination, made by a medical practitioner or registered nurse, of whether a client's medication is achieving the desired effect.
93. "Medication organizer" means a container divided according to date or time increments and designated to hold medication.
94. "Medication services" means one or more of the following:
    a. Medication administration,
    b. Medication monitoring, or
    c. Medication adjustment.
95. "Mental disorder" has the same meaning as in:
    a. A.R.S. § 36-501; or
    b. For an individual receiving treatment as a sexually violent person according to A.R.S. Title 36, Chapter 37, A.R.S. § 36-3701.
96. "Mental health care power of attorney" means a written designation of an agent to make mental health care decisions that meets the requirements of section 36-3281.
97. "Misdemeanor domestic violence offender treatment program" means a behavioral health service provided to an individual convicted of a misdemeanor domestic violence offense and ordered by a court to complete domestic violence offender treatment according to A.R.S. § 13-3601.01.
98. "Neglect" means a pattern of conduct resulting in deprivation of food, water, medication, treatment, medical services, shelter, cooling, heating, or ancillary services necessary to maintain minimum physical or behavioral health.
99. "NFPA" means National Fire Protection Association.
100. "Nurse" means an individual licensed as a registered nurse or a practical nurse according to A.R.S. Title 32, Chapter 15.
101. "Nurse practitioner" means an individual certified as a registered nurse practitioner according to A.R.S. Title 32, Chapter 15.
102. "Nursing assessment" means the collection of data on an individual's medical history and current physical health status and the analysis of that data performed by a registered nurse.
103. "OBHL" means the Department's Office of Behavioral Health Licensure.
104. "On-call" means the immediate availability of an individual in person, by telephone, or other electronic means.
105. "Opioid treatment" means dispensing a medication, medication administration, or other treatment that includes an opioid agonist treatment medication, to alleviate or eliminate an individual's dependence upon an opioid drug.

106. "Orientation" means familiarizing an individual with a new setting or situation.
107. "Outing" means a planned activity sponsored by an agency that:
    a. Occurs off the premises,
    b. Is not part of the agency's regular program or daily routine, and
    c. Lasts for more than four hours or occurs in a location where emergency medical services cannot be anticipated to respond within 12 minutes.
108. "Outpatient clinic" means an agency that provides treatment for a specific portion of a day to a client who does not live on the premises.
109. "Owner" means a person who appoints, elects, or otherwise designates a health care institution's governing authority.
110. "Partial care" means a day program that provides counseling or medication services at an outpatient clinic.
111. "Person" has the same meaning as in A.R.S. § 1-215.
112. "Personal funds account" means client monies that are held and managed by a licensee according to the requirements in R9-20-403(C) and (D).
113. "Personal restraint" means the application of physical force without the use of any device, for the purpose of restricting the free movement of a client's body, but for a level one RTC or a Level one sub-acute agency does not include:
    a. Briefly holding, without undue force, a client in order to calm or comfort the client; or
    b. Holding a client's hand to safely escort the client from one area to another.
114. "Personality disorder" means an enduring, pervasive, and lifelong pattern of behavior that deviates from the expectations of an individual's culture; leads to an individual's functional impairment and distress; and has been diagnosed by a behavioral health professional.
115. "Pharmacist" means an individual licensed according to A.R.S. Title 32, Chapter 18.
116. "Pharmacological abuse" means administration of medication:
    a. For purposes of discipline, convenience, retaliation, or coercion; and
    b. That is not required to treat a client's medical or behavioral health issue.
117. "Physical examination" means the collection of data on an individual's medical history and current physical health and the analysis of the data by a medical practitioner.
118. "Physician" means an individual licensed according to A.R.S. Title 32, Chapter 13 or 17.
119. "Physician assistant" means an individual licensed according to A.R.S. Title 32, Chapter 25.
120. "Premises" means a licensed facility and the facility's contiguous grounds or a branch office where behavioral health services are provided.
121. "Prepetition screening" has the same meaning as in A.R.S. Title 36, Chapter 5.
122. "Presenting issue" means one or more behavioral health issues that are the reason for an individual's seeking or needing behavioral health services.
123. "PRN" means pro re nata or given as needed.
124. "Professionally recognized treatment" means a behavioral health service that is:
    a. Supported by research results published in a nationally recognized journal, such as the Journal of the American Psychiatric Association, the Journal of the American Medical Association, or the Journal of Psychiatric Rehabilitation; or
    b. A generally accepted practice as determined by a Department approved psychiatrist or psychologist.
125. "Progress note" means documentation of:
    a. A behavioral health service or medical service provided to a client and the client's response that is observed,
    b. A client's significant change in condition, or
    c. Staff member observations of client behavior.
126. "Psychiatrist" has the same meaning as in A.R.S. § 36-501.
127. "Psychologist" means an individual licensed according to A.R.S. Title 32, Chapter 19.1.
128. "Referral" means assistance or direction provided to an individual to enable the individual to obtain information, behavioral health services, medical services, or ancillary services.
129. "Regional behavioral health authority" means an organization under contract with the department to coordinate the delivery of mental health services in a geographically specific service area of the state for eligible persons.
130. "Registered nurse" means an individual licensed as a graduate nurse, professional nurse, or registered nurse according to A.R.S. Title 32, Chapter 15.
131. "Representative payee" means an individual authorized by the Social Security Administration to receive and manage the money a client receives from the Social Security Administration.
132. "Research" means the systematic study of a field of knowledge.
133. "Residential agency" means a:
    a. Level 2 behavioral health residential agency, or
    b. Level 3 behavioral health residential agency.

134. "Respite" means short term behavioral health services or general client supervision that provides rest or relief to a family member or other individual caring for the client and that is provided in:
    a. A Level 1 sub-acute agency,
    b. A Level 1 RTC,
    c. A Level 2 behavioral health residential agency,
    d. A Level 3 behavioral health residential agency, or
    e. An adult therapeutic foster home.
135. "Restraint" means personal restraint, mechanical restraint, or drug used as a restraint.
136. "Rural substance abuse transitional center" means an agency, located in a county with a population of fewer than 500,000 individuals according to the most recent U.S. decennial census, that provides behavioral health services to an individual who is intoxicated or has a substance abuse problem.
137. "Seclusion" means the involuntary confinement of a client in a room or an area from which the client cannot leave.
138. "Secure facility" means the premises or portion of the premises that is locked or from which a client cannot leave without a key, special knowledge, or special effort.
139. "Seriously mentally ill" means persons, who as a result of a mental disorder as defined in section 36-501 exhibit emotional or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment and recreation.
140. "Shelter for victims of domestic violence" or "shelter" means a facility providing temporary residential service or facilities to family or household members who are victims of domestic violence.
141. "Significant change in condition" means a deterioration or improvement in a client's physical or behavioral health that may require a modification in the client's treatment.
142. "Significant other" means an individual whose participation the client considers to be essential to the effective provision of behavioral health services to the client.
143. "Social worker" means:
    a. An individual who is certified as a baccalaureate social worker, master social worker, or independent social worker, according to A.R.S. Title 32, Chapter 33, Article 5;
    b. Until October 3, 2003, an individual who is certified by the National Association of Social Workers; or
    c. An individual who is licensed or certified to practice social work by a government entity in another state if the individual:
        i. Has documentation of submission of an application for certification as a baccalaureate social worker, master social worker, or independent social worker according to A.R.S. Title 32, Chapter 33, Article 5; and
        ii. Is certified as a baccalaureate social worker, master social worker, or independent social worker according to A.R.S. Title 32, Chapter 33, Article 5 within two years after submitting the application.
144. "Staff member" means an individual who is employed by or under contract with a licensee to provide behavioral health services to an agency client and who is a:
    a. Behavioral health professional,
    b. Behavioral health technician, or
    c. Behavioral health paraprofessional.
145. "Subclass" means a type of behavioral health service agency listed in R9-20-102(A).
146. "Substance abuse" means the misuse of alcohol or another chemical or drug that:
    a. Alters an individual's behavior or mental functioning;
    b. May cause psychological or physiological dependence; and
    c. Impairs, reduces, or destroys the individual's social or economic functioning.
147. "Substance abuse counselor" means:
    a. An individual who is certified as a substance abuse counselor according to A.R.S. Title 32, Chapter 33, Article 8; or
    b. An individual who is certified by the Arizona Board of Certified Addiction Counselors.
148. "Therapeutic diet" means one of the following ordered for an individual by a medical practitioner:
    a. Food, or
    b. The manner in which food is to be prepared.
149. "Time out" means providing a client an opportunity to regain self-control in a designated area from which the client is not physically prevented from leaving.
150. "Transfer" means moving a client from one agency to another agency that assumes responsibility for the treatment of the client.
151. "Treatment" means:

a. A professionally recognized treatment that is provided to a client or the client's family to improve, eliminate, or manage the client's behavioral health issue; or
b. For court-ordered alcohol treatment, the same as in A.R.S. § 36-2021.

152. "Treatment goal" means the desired result or outcome of treatment.
153. "Treatment method" means the specific approach used to achieve a treatment goal.
154. "Treatment plan" means a description of the specific behavioral health services that an agency will provide to a client that is documented in the client record.
155. "Volunteer" means an individual who provides a behavioral health service or ancillary service at an agency without compensation.
156. "Working day" means Monday, Tuesday, Wednesday, Thursday, or Friday, excluding state and federal holidays.

R9-20-102. ~~Licensure Requirements; Exceptions~~ Agency Subclasses and Required and Authorized Services

~~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.~~

A. A person may apply for an agency to be licensed in one or more of the following agency subclasses:
1. Outpatient clinic,
2. Level 2 behavioral health residential agency,
3. Level 3 behavioral health residential agency,
4. Level 1 psychiatric acute hospital,
5. Level 1 RTC,
6. Level 1 sub-acute agency,
7. Level 1 specialized transitional agency,
8. Level 4 transitional agency,
9. Shelter for victims of domestic violence,
10. Rural substance abuse transitional agency, or
11. Adult therapeutic foster home.

B. If an agency is licensed as:
1. An outpatient clinic, the licensee of the agency:
   a. Shall comply with:
      i. Article 2, and
      ii. R9-20-301; and
   b. May request authorization to provide:
      i. Counseling according to R9-20-302,
      ii. Medication services according to R9-20-303,
      iii. Assistance in the self-administration of medication according to R9-20-408,

iv. Pre-petition screening according to R9-20-801,
v. Court-ordered evaluation according to R9-20-802,
vi. Court-ordered treatment according to R9-20-803,
vii. DUI screening according to R9-20-901 and R9-20-902,
viii. DUI education according to R9-20-901 and R9-20-903,
ix. DUI treatment according to R9-20-904,
x. Opioid treatment according to Article 10, or
xi. Misdemeanor domestic violence offender treatment according to Article 11;

2. A Level 2 behavioral health residential agency, the licensee of the agency:
   a. Shall comply with:
      i. Article 2,
      ii. R9-20-401 through R9-20-407, and
      iii. R9-20-409;
   b. Shall provide:
      i. Counseling according to R9-20-302, and
      ii. Assistance in the self-administration of medication according to R9-20-408; and
   c. May request authorization to provide:
      i. Medication services according to R9-20-303,
      ii. Pre-petition screening according to R9-20-801,
      iii. Court-ordered evaluation according to R9-20-802, or
      iv. Court-ordered treatment according to R9-20-803;
3. A Level 3 behavioral health residential agency, the licensee of the agency:
   a. Shall comply with:
      i. Article 2,
      ii. R9-20-401 through R9-20-407, and
      iii. R9-20-410;
   b. Shall provide assistance in the self-administration of medication according to R9-20-408; and
   c. May request authorization to provide:
      i. Counseling according to R9-20-302,
      ii. Medication services according to R9-20-303,
      iii. Pre-petition screening according to R9-20-801,
      iv. Court-ordered evaluation according to R9-20-802, or
      v. Court-ordered treatment according to R9-20-803;
4. A Level 1 psychiatric acute hospital, the licensee of the agency:
   a. Shall comply with:
      i. Article 2,
      ii. R9-20-501, and
      iii. R9-20-502;
   b. Shall provide:
      i. Counseling according to R9-20-302,
      ii. Medication services according to R9-20-303, and
      iii. If the agency is certified under Title XIX of the Social Security Act, restraint or seclusion according to Article 6; and
   c. May request authorization to provide:
      i. Crisis services according to R9-20-503,
      ii. Detoxification services according to R9-20-504,
      iii. Pre-petition screening according to R9-20-801,
      iv. Court-ordered evaluation according to R9-20-802,
      v. Court-ordered treatment according to R9-20-803; or
      vi. If the agency is not certified under Title XIX of the Social Security Act, restraint or seclusion according to Article 6;
5. A Level 1 RTC, the licensee of the agency:
   a. Shall comply with:
      i. Article 2,
      ii. R9-20-501, and
      iii. R9-20-505;
   b. Shall provide:
      i. Counseling according to R9-20-302,
      ii. Medication services according to R9-20-303, and

iii. Restraint or seclusion according to Article 6; and
c. May request authorization to provide:
i. Assistance in the self-administration of medication according to R9-20-408,
ii. Detoxification services according to R9-20-504,
iii. Pre-petition screening according to R9-20-801,
iv. Court-ordered evaluation according to R9-20-802, or
v. Court-ordered treatment according to R9-20-803;
6. A Level 1 sub-acute agency, the licensee of the agency:
a. Shall comply with:
i. Article 2,
ii. R9-20-501, and
iii. R9-20-506;
b. Shall provide:
i. Counseling according to R9-20-302,
ii. Medication services according to R9-20-303, and
iii. If the agency is certified under Title XIX of the Social Security Act, restraint or seclusion according to Article 6; and
c. May request authorization to provide:
i. Assistance in the self-administration of medication according to R9-20-408,
ii. Crisis services according to R9-20-503,
iii. Detoxification services according to R9-20-504,
iv. If the agency is not certified under Title XIX of the Social Security Act, restraint or seclusion according to Article 6,
v. Pre-petition screening according to R9-20-801,
vi. Court-ordered evaluation according to R9-20-802, or
vii. Court-ordered treatment according to R9-20-803;
7. Level 1 specialized transitional agency, the licensee of the agency:
a. Shall comply with:
i. Article 2,
ii. R9-20-501, and
iii. Article 7;
b. Shall provide:
i. Counseling according to R9-20-302,
ii. Medication services according to R9-20-303, and
iii. Restraint or seclusion according to Article 6; and
c. May request authorization to provide assistance in the self-administration of medication according to R9-20-408;
8. A Level 4 transitional agency, the licensee of the agency:
a. Shall comply with Article 12, and
b. May request authorization to provide assistance in the self-administration of medication according to R9-20-408;
9. A shelter for victims of domestic violence, the licensee of the agency:
a. Shall comply with Article 13, and
b. May request authorization to provide assistance in the self-administration of medication according to R9-20-408;
10. A rural substance abuse transitional agency, the licensee of the agency:
a. Shall comply with Article 14, and
b. May request authorization to provide:
i. Medication services according to R9-20-303, or
ii. Assistance in the self-administration of medication according to R9-20-408; and
11. An adult therapeutic foster home, the licensee of the agency:
a. Shall comply with Article 15, and
b. May request authorization to provide assistance in the self-administration of medication according to R9-20-408.

C. A licensee shall only operate a subclass or provide a behavioral health service listed on the agency's license.

R9-20-103. ~~Licensure Procedure~~ Initial License Application

~~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.~~

A. According to A.R.S. § 36-422, a person applying for an initial license to operate an agency shall submit:
1. An application packet that includes:
a. A Department-provided application form signed according to A.R.S. § 36-422(B) and notarized that contains:
i. The name of the agency;
ii. The agency's street address, mailing address, telephone number and fax number;
iii. Whether the agency is operated as a proprietary or non-proprietary institution;
iv. The name of the owner;
v. The name and qualifications of the agency's chief administrative officer;
vi. The agency subclass or subclasses for which licensure is requested and if more than one subclass is requested, the location of each subclass on the premises;
vii. Whether the person applying for a license or a person with a 10 percent or greater interest in the agency has previously held a health care institution license in any state or jurisdiction;
viii. Whether the person applying for a license or a person with a 10 percent or greater interest in the agency has had a health care institution license suspended, denied, or revoked in any state or jurisdiction;
ix. Whether the person applying for a license or a person with a 10 percent or greater interest in the agency has had civil penalties assessed against a health care institution operated in any state by the person applying for a license or the owner;

x. Whether the person applying for a license or a person with a 10 percent or greater interest in the agency has had a professional or occupational license, other than a driver license, denied, revoked, or suspended in any state or jurisdiction; and
xi. Whether the person applying for a license or a person with a 10 percent or greater interest in the agency has been convicted, in any state or jurisdiction, of any felony or misdemeanor involving moral turpitude, including conviction for any crime involving abuse, neglect, or exploitation of another;

b. If the person applying for a license or a person with a 10 percent or greater interest in the agency answered yes to subsection (A)(1)(a)(vii), the health care institution's name, the license number, and the licensure dates on an attached sheet;
c. If the person applying for a license or a person with a 10 percent or greater interest in the agency answered yes to any of the questions in subsection (A)(1)(a)(viii) through (A)(1)(a)(xi), the details of each assessment of a civil penalty; each denial, suspension, or revocation; or each conviction on an attached sheet, including:
   i. The type of action,
   ii. The date of the action, and
   iii. The name of the court or entity having jurisdiction over the action;
d. The name of the governing authority;
e. Owner information including:
   i. The type of organization, if applicable;
   ii. The owner's address;
   iii. The name, title, and address of the owner's statutory agent, members of the board of directors, or of the individual designated by the owner to accept service of process and subpoenas; and
   iv. A copy of the bylaws and articles of incorporation, partnership or joint venture documents, or limited liability company documents, if applicable;
f. The behavioral health services listed in R9-20-102 for which the agency is requesting authorization;
g. The population for whom the licensee intends to provide behavioral health services at the agency;
h. The requested licensed capacity for the agency, including:
   i. The number of inpatient beds requested for individuals younger than 18 years of age, and
   ii. The number of inpatient beds requested for individuals 18 years of age or older;
   iii. The number of toilets, sinks, showers, and tubs at the agency;
j. A program description completed according to R9-20-201(A)(2);
k. A list of the agency's branch offices, including:
   i. Each branch office's address,
   ii. Each branch office's hours of operation, and
   iii. Each behavioral health service provided at each branch office;
l. A document issued by the local jurisdiction with authority certifying that the facility complies with all applicable local building codes;
m. A copy of a current fire inspection conducted by the local fire department or the Office of the State Fire Marshal, and any plan of correction in effect;
n. If the agency is required to have a food establishment license according to 9 A.A.C. 8, Article 1, a copy of the most recent food establishment inspection report for the agency and any plan of correction in effect;
o. Whether the licensee is requesting, for the agency, certification under Title XIX of the Social Security Act;
p. Whether the agency is accredited by a nationally recognized accreditation organization, and if so:
   i. The name of nationally recognized accreditation organization that accredited the agency;
   ii. If accredited by the Joint Commission on Accreditation of Health Care Organizations, whether the agency was accredited under the inpatient standards or community behavioral health standards;
   iii. If the applicant is submitting an accreditation report in lieu of all licensing inspections conducted by the Department, a copy of the accreditation report; and
   iv. The dates of the accreditation period;
q. Whether the agency has a contract with a:
   i. Regional behavioral health authority and, if so, the name of the contracted regional behavioral health authority; and
   ii. Government entity, such as the Administrative Office of the Courts, Department of Juvenile Justice, the Department of Economic Security, or a tribal government;
r. The name of each staff member, intern, or volunteer employed or under contract with the agency; whether each staff member is a behavioral health professional, behavioral health technician, or behavioral health paraprofessional; the professional or occupational license or certification number of each behavioral health professional; and the number on each staff member's fingerprint clearance card, if applicable;
s. The licensee's organizational chart showing all staff member positions and the lines of supervision, authority, and accountability for the agency; and

t. Whether the facility, or portion of the facility, used by clients is a secure facility and, if so:
i. The number of beds in the secure facility; and
ii. The number of beds in the secure facility that are designated for children and adults; and
2. The fees required in 9 A.A.C. 10, Article 1.

B. The Department shall approve or deny an application in this Section according to R9-20-105 and R9-20-108.

R9-20-104. ~~Initial License~~ License Renewal

~~**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.~~

A. To renew a license, a licensee shall submit the following information to the Department at least 60 days but not more than 120 days before the expiration date of the current license:
1. An application packet that complies with R9-20-103(A)(1); and
2. The fees required in 9 A.A.C. 10, Article 1.

B. Unless the licensee submits a copy of the agency's accreditation report from a nationally recognized accreditation organization, the Department shall conduct an on-site inspection of the agency to determine if the licensee and the agency are in substantial compliance with the applicable statutes and this Chapter.

C. The Department shall approve or deny a license renewal according to R9-20-105 and R9-20-108.

D. A renewal license remains in effect for:
1. One year, if the licensee is in substantial compliance with the applicable statutes and this Chapter, and the licensee agrees to implement a plan acceptable to the Department to eliminate any deficiencies;
2. Two years, if the licensee has no deficiencies at the time of the Department's licensure inspection; or
3. The duration of the accreditation period, if:
a. The licensee's agency is a hospital accredited by a nationally recognized accreditation organization, and
b. The licensee submits a copy of the hospital's accreditation report.

R9-20-105. ~~Renewal License~~ Time-frames

~~**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.~~

A. The overall time-frame described in A.R.S. § 41-1072 for each license or approval issued by the Department according to this Chapter is listed in Table 1. The person applying for a license or requesting approval and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame. The substantive review time-frame and the overall time-frame may not be extended by more than 25 percent of the overall time-frame.

B. The administrative completeness review time-frame described in A.R.S. § 41-1072 for each license or approval issued by the Department according to this Chapter is listed in Table 1. The administrative completeness review time-frame begins on the date that the Department receives an application packet or request for approval.

1. If the application packet or request for approval is incomplete, the Department shall provide a written notice to the person applying for a license or requesting approval specifying the missing documents or incomplete information. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice until the date the Department receives the missing documents or information.
2. When an application packet or request for approval is complete, the Department shall provide a written notice of administrative completeness to the person applying for a license or requesting approval.
3. The Department shall consider an application or request for approval withdrawn if the person applying for a license or requesting approval fails to supply the missing documents or information according to subsection (B)(1) within 120 days after the date of the written notice described in subsection (B)(1).
4. If the Department issues a license or approval during the time provided to assess administrative completeness, the Department shall not issue a separate written notice of administrative completeness.

C. The substantive review time-frame described in A.R.S. § 41-1072 for each license or approval issued by the Department according to this Chapter is listed in Table 1 and begins on the date of the notice of administrative completeness.

1. The Department may conduct an on-site inspection of the premises as part of the substantive review for an initial or renewal license application or a request for approval of a change affecting a license.
2. During the substantive review time-frame, the Department may make one comprehensive written request for additional information or documentation. If the Department and the person applying for a license or requesting approval agree in writing, the Department may make supplemental requests for additional information or documentation. The time-frame for the Department to complete the substantive review is suspended from the date of a written request for additional information or documentation until the Department receives the additional information or documentation.
3. The Department shall send a license or a written notice of approval to a person applying for a license or requesting approval who is in substantial compliance with the applicable statutes and this Chapter and who agrees to carry out a plan of correction acceptable to the Department for any deficiencies.
4. The Department shall send a written notice of denial according to A.R.S. § 41-1092.03 to a person applying for a license or requesting approval who does not:
   a. Submit the information or documentation in subsection (C)(2) within 120 days after the Department's comprehensive written request or supplemental request; or
   b. Substantially comply with the applicable statutes and this Chapter.
5. If a time-frame's last day falls on a Saturday, a Sunday, or an official state holiday, the Department shall consider the next business day to be the time-frame's last day.

Table 1. Time-frames (in days)

Type of Approval	Statutory Authority	Overall Time-frame	Administrative Completeness Time-frame	Substantive Review Time-frame
Initial license R9-20-103	A.R.S. §§ 36-405, 36-407, 36-422, 36-424, and 36-425	180	30	150
Renewal license R9-20-104	A.R.S. §§ 36-405, 36-407, 36-422, 36-424, and 36-425	180	30	150
Change affecting a license R9-20-106	A.R.S. §§ 36-405, 36-407, 36-422, 36-424, and 36-425	90	30	60

R9-20-106. ~~Provisional License~~ Changes Affecting a 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.~~

A. A licensee shall ensure that the Department is notified in writing at least 30 days before the effective date of a change in the name of:
1. The agency, or
2. The licensee.

B. A person shall submit an application for an initial license as required in R9-20-103 for a change in an agency's:
1. Owner,
2. Address or location, or
3. Subclass.

C. A licensee shall submit a request for approval of a change affecting a license to the Department at least 30 days before the date of:
1. An intended change in an agency's authorized services,
2. An intended change in an agency's licensed capacity, or
3. An intended expansion of an agency's premises.

D. A request for approval of a change affecting a license shall include:
1. The name of the licensee;
2. The name of the agency;
3. The agency's street address, mailing address, and telephone number;
4. The agency's license number;
5. The type of change intended;
6. A narrative description of the intended change;
7. A program description completed according to R9-20-201(A)(2) and including the intended change;
8. For a change in authorized services, a list of the services that the licensee intends to add and delete;
9. For a change in licensed capacity, a floor plan showing the following for each story of a facility:
   a. Room layout;
   b. Room usage;
   c. The dimensions of each bedroom;
   d. The number of beds to be placed in each bedroom;
   e. The location of each window;
   f. The location of each exit;
   g. The location of each sink, toilet, and shower or bathtub to be used by clients; and
   h. The location of each fire extinguisher and fire protection device; and
10. For an expansion of an agency's premises, a floor plan completed according to subsection (D)(9) and a site plan showing the locations of the following on the expanded premises:
    a. Buildings or other structures,
    b. Property lines,
    c. Streets,
    d. Walkways,
    e. Parking areas,
    f. Fencing,
    g. Gates, and
    h. If applicable, swimming pools.

E. The Department shall review a request for approval of a change affecting a license in accordance with R9-20-105. The Department may conduct an on-site inspection as part of the substantive review for a request for a change affecting a license.
1. If the agency will be in substantial compliance with the applicable statutes and this Chapter with the intended change, and the licensee agrees to carry out a plan of correction acceptable to the Department for any deficiencies, the Department shall send the licensee an amended license that incorporates the change but retains the expiration date of the current license.
2. If the agency will not be in substantial compliance with the applicable statutes and this Chapter with the intended change, the Department shall deny the request for approval.

F. A licensee shall not implement any change described in this Section until the Department issues a changed license or a new license.

R9-20-107. ~~Inspections~~ Enforcement Actions

~~**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.~~

A. If the Department determines that a person applying for a license or a licensee is not in substantial compliance with the applicable statutes and this Chapter, the Department may:

1. Issue a provisional license to the person applying for a license or the licensee according to A.R.S. § 36-425,
2. Assess a civil penalty according to A.R.S. § 36-431.01,
3. Impose an intermediate sanction according to A.R.S. § 36-427,
4. Remove a licensee and appoint temporary personnel to continue operation of the agency pending further action According to A.R.S. § 36-429,
5. Suspend or revoke a license according to R9-20-108 and A.R.S. § 36-427,
6. Deny a license according to R9-20-108, or
7. Issue an injunction according to A.R.S. § 36-430.

B. In determining which action in subsection (A) is appropriate, the Department shall consider the threat to the health, safety, and welfare of an agency's clients based on the licensee's:

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.

R9-20-108. ~~Complaint Investigations~~ Denial, Revocation, or Suspension of a License

~~**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.~~

The Department may deny, revoke, or suspend a license to operate an agency if:
1. A person applying for a license, a licensee, or a person with a 10 percent or greater interest in the agency:
   a. Provides false or misleading information to the Department;
   b. Has had in any state or jurisdiction either of the following:
      i. An application or license to operate an agency denied, suspended, or revoked, unless the denial was based on failure to complete the licensing process according to a required time-frame; or
      ii. A professional or occupational license or certificate denied, revoked, or suspended; or
   c. Has operated a health care institution, within the ten years before the date of the license application, in violation of applicable statutes and endangering the health or safety of clients; or
2. A person applying for a license or a licensee:
   a. Fails to substantially comply with an applicable statute or this Chapter; or
   b. Substantially complies with the applicable statutes and this Chapter, but refuses to carry out a plan of correction acceptable to the Department for any deficiencies that are listed on the Department's statement of deficiency.

R9-20-109. ~~Plan of Correction~~ Repealed

~~**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.~~

R9-20-110. ~~Department Reports and Records~~ Repealed

~~**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.~~

R9-20-111. ~~Required Reports~~ Repealed

~~**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.~~

R9-20-112. C~~lient Fees and Charges~~ Repealed

~~**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.~~

R9-20-113. ~~Research~~ Repealed

~~**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.~~

R9-20-114. ~~Grievance Procedure~~ Repealed

~~**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.~~

~~ARTICLE 2. CLIENT RIGHTS~~ UNIVERSAL RULES

R9-20-201. ~~Administration~~

~~**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.~~

ARTICLE 2. UNIVERSAL RULES

R9-20-201. Administration

A. A licensee is responsible for the organization and management of an agency. A licensee shall:
1. Ensure compliance with:
   a. This Chapter and applicable federal, state, and local law;
   b. If the agency provides a behavioral health service to an individual who is enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, 9 A.A.C. 21; and
   c. If the agency provides a behavioral health service to a child, A.R.S. § 36-425.03;
2. For each subclass for which the licensee is licensed, adopt, maintain, and have available at the agency for public review, a current written program description that includes:
   a. A description of the subclass;
   b. Program goals;
   c. A description of each behavioral health service listed in R9-20-102(B) that the agency provides;
   d. If the agency is authorized to provide counseling:
      i. Whether individual, family, or group counseling is provided;
      ii. Whether counseling that addresses a specific type of behavioral health issue, such as substance abuse or a crisis situation, is provided; and
      iii. The type and amount of counseling offered by the agency each week;
   e. Each population served by the agency, such as children, adults age 65 or older, individuals who are seriously mentally ill, individuals who have substance abuse problems, or individuals who have co-occurring disorders;
   f. The hours and days of agency operation;
   g. Whether the agency provides behavioral health services off the premises and, if so, the behavioral health services that are provided off the premises;
   h. Criteria for:
      i. Admitting and re-admitting an individual into the agency,
      ii. Placing an individual on a waiting list,
      iii. Referring an individual to another agency or entity,
      iv. Discharging a client, including an involuntary discharge,
      v. Transferring a client, and
      vi. Declining to provide behavioral health services or treatment to an individual;
   i. The minimum qualifications, experience, training, and skills and knowledge specific to the behavioral health services the agency is authorized to provide and the populations served by the agency that staff members are required to possess;
   j. Policies and procedures for receiving a fee from and refunding a fee to a client or a client's parent, guardian, or custodian;
   k. The availability of behavioral health services for an individual who does not speak English;
   l. The accommodations made to the premises for individuals with a mobility impairment, sensory impairment, or other physical disability;
   m. If an outpatient clinic provides partial care, the days and times that counseling or medication services are available; and
   n. For an inpatient treatment program or a residential agency:
      i. Whether the agency provides treatment in a secure facility,
      ii. The client-to-staff ratios for day, evening, and night shifts, and
      iii. Whether the agency chooses to manage client funds through a personal funds account;
3. Approve, sign, and date initial and updated policies and procedures required by this Chapter;
4. Establish minimum qualifications for an administrator;
5. Designate an administrator who:
   a. Meets the qualifications established by the licensee;
   b. Has the authority and responsibility to operate the agency according to the requirements in this Chapter;
   c. Has access to all areas of the premises; and
   d. Appoints a designee, in writing, to act as the administrator when the administrator is not on the premises;
6. Designate a clinical director who:
   a. Oversees behavioral health services;
   b. Is one of the following:
      i. A behavioral health professional, or

ii. A behavioral health technician with a combination of full-time behavioral health work experience and education in a field related to behavioral health totaling at least six years; and
c. May be the same individual as the administrator;
7. Notify the OBHL if the administrator or clinical director changes and provide to the OBHL, in writing, the new individual's name and qualifications within 30 days after the effective date of the change;
8. Ensure that the Department is allowed immediate access to:
a. The premises, an administrative office, or a branch office; or
b. A client; and
9. Ensure that a record, report, or document required to be maintained by this Chapter or federal, state, or local law is provided to the Department as soon as possible upon request and no later than:
a. Two hours after the time of a request, for a current client;
b. Three working days after the time of a request, for a former client; or
c. Two hours after the time of a request for a record, report, or document that does not directly concern a client, such as a staffing schedule or a fire inspection report.

B. A licensee shall ensure that:
1. The administrator or clinical director develops, implements, and complies with policies and procedures that:
a. Ensure the health, safety, and welfare of a client on the premises; on an agency-sponsored activity off the premises; and on an outing;
b. Ensure that client records and information are maintained and protected according to R9-20-211;
c. Establish specific steps and deadlines for:
i. Responding to and resolving client grievances; and
ii. Obtaining documentation of fingerprint clearance, if applicable;
d. Ensure that incidents listed in R9-20-202(A)(1) are reported and investigated;
e. Address whether pets and animals are allowed on the premises;
f. Require an agency that is involved in research to establish or use a Human Subject Review Committee;
g. Explain the process for receiving a fee from and refunding a fee to a client or a client's parent, guardian, or custodian; and
h. For a residential agency or an inpatient treatment program:
i. Establish the process for obtaining client preferences for social, recreational, or rehabilitative activities and meals and snacks;
ii. Ensure the security of a client's possessions that are allowed on the premises;
iii. Address smoking on the premises;
iv. Address requirements regarding pets or animals on the premises; and
v. Ensure the safety of clients;
2. The clinical director develops, implements, and complies with policies and procedures that:
a. Establish minimum qualifications, duties, and responsibilities of staff members, interns, and volunteers;
b. Establish a process for determining whether a staff member has the qualifications, training, experience, and skills and knowledge necessary to provide the behavioral health services that the agency is authorized to provide and to meet the treatment needs of the populations served by the agency;
c. Establish a code of ethical conduct for staff members, interns, and volunteers and consequences for violating the code of ethical conduct;
d. Establish a process for orientation of staff members;
e. Ensure that staffing is provided according to the requirements in this Chapter;
f. Ensure that a staff member receives sufficient direction to perform the staff member's job duties;
g. Describe the processes for providing the behavioral health services listed in the program description required in R9-20-201(A)(2);
h. Establish the process for admitting a client;
i. Establish the process for providing a referral to a client;
j. Ensure communication and coordination, consistent with the release of information requirements in R9-20-211(A)(3) and (B), with:
i. A client's family member, guardian, custodian, designated representative, or agent;
ii. The individual who coordinates the client's behavioral health services or ancillary services;
iii. Other persons who provide behavioral health services or medical services to the client, such as a medical practitioner responsible for providing or coordinating medical services for a client; or
iv. Governmental agencies that provide services to the client, such as the Department of Economic Security or a probation or parole entity;
k. Establish the process for developing and implementing a client's assessment and treatment plan;
l. Establish the processes for providing medication services to a client, if applicable;
m. Establish the process for transferring and discharging a client;

n. Establish the process for warning an identified or identifiable individual, as described in A.R.S. § 36-517.02(B) through (C), if a client communicates to a staff member a threat of imminent serious physical harm or death to the individual and the client has the apparent intent and ability to carry out the threat; and
o. For a residential agency or an inpatient treatment program:
    i. Establish requirements regarding clients, staff members, and other individuals entering and exiting the premises;
    ii. Establish guidelines for meeting the needs of an individual residing at an agency with a client, such as a child accompanying a parent in treatment, if applicable; and
    iii. Establish the process for responding to a client's need for immediate and unscheduled behavioral health services or medical emergency;
3. The administrator or clinical director reviews and, if necessary, updates policies and procedures at least once every 24 months;
4. When a policy or procedure is approved or updated, each staff member whose duties are impacted by the policy and procedure reviews the policy and procedure within 30 days after the policy and procedure is approved or updated; and
5. Each review of a policy and procedure is documented, and the documentation is maintained on the premises or at the administrative office.

C. A licensee shall ensure that:
1. The following documents are maintained on the premises or at the administrative office:
    a. The licensee's bylaws, if any;
    b. A contractual agreement with another person to provide behavioral health services or ancillary services for a client as required in this Chapter, if any;
    c. Documentation of ownership or control of the premises;
    d. The licensee's organizational chart showing all staff member positions and the lines of supervision, authority, and accountability for the agency;
    e. A list of the names of clients;
    f. A list of the names of clients discharged within the past 12 months;
    g. Reports of incidents required to be reported under R9-20-202;
    h. Fire inspection reports required by this Chapter;
    i. Documentation of fire drills required by R9-20-214(H); and
    j. Food establishment inspection reports, if applicable;
2. A current copy of each of the following documents is maintained on the premises and is available and accessible to a staff member or client or a client's family member, guardian, custodian, designated representative, or agent:
    a. A policy and procedure required by this Chapter;
    b. An inspection report prepared by the Department or, if the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, the most recent report of inspection conducted by the nationally recognized accreditation agency;
    c. Each plan of correction with the Department in effect within the past five years or, if the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, a plan of correction in effect as required by the nationally recognized accreditation agency;
    d. 9 A.A.C. 20;
    e. If the agency provides behavioral health services to an individual enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, 9 A.A.C. 21;
    f. A.R.S. Title 36, Chapters 4 and 5; and
    g. The agency's refund policy and procedures; and
3. The following information or documents are conspicuously posted on the premises and are available upon request to a staff member or client or a client's family member, guardian, custodian, designated representative, or agent:
    a. The client rights listed in R9-20-203, in English and Spanish;
    b. If the agency provides behavioral health services to an individual who is enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, the client rights listed in 9 A.A.C. 21 that are required to be conspicuously posted;
    c. The current telephone number and address of:
        i. The OBHL;
        ii. The Department's Division of Behavioral Health Services;
        iii. Human rights advocates provided by the Department or the Department's designee;
        iv. The Arizona Department of Economic Security Office of Adult Protective Services, if applicable;
        v. The Arizona Department of Economic Security Office of Child Protective Services, if applicable; and
        vi. The local office of the regional behavioral health authority, if applicable;

d. The location at the agency where inspection reports are available for review;
e. The licensee's grievance policy and procedure; and
f. For a residential agency or an inpatient treatment program, the days, times, and locations in the facility where a client may accept visitors and make telephone calls.

D. A licensee shall ensure that a staff member receives a written performance review at least once every 12 months that contains:
1. The name and title of the individual conducting the performance review; and
2. The name, signature, and professional credential or job title of the staff member receiving the performance review and the date signed.

E. A licensee shall ensure that:
1. A client or, if applicable, a family member, guardian, custodian, designated representative, or agent receives written notice at least 30 days before the licensee changes a fee that a client is required to pay;
2. The notice required in subsection (E)(1) is:
   a. Conspicuously posted in the facility; and
   b. Provided to a client or, if applicable, a family member, guardian, custodian, designated representative, or agent;
3. Labor performed by a client for an agency is consistent A.R.S. § 36-510 and applicable state and federal law;
4. A client has privacy in treatment and is not fingerprinted, photographed, or recorded without consent, except:
   a. For photographing for identification and administrative purposes, as provided by A.R.S. § 36-507(2);
   b. For a client receiving treatment according to A.R.S. Title 36, Chapter 37; or
   c. For temporary video recordings used for security purposes;
5. A client who is a child is only released to the child's custodial parent, guardian, or custodian or as authorized in writing by the child's custodial parent, guardian, or custodian;
6. The licensee obtains documentation of the identity of the parent, guardian, custodian, or family member authorized to act on behalf of a client who is a child; and
7. A client who is an incapacitated person according to A.R.S. § 14-5101 or who is gravely disabled is assisted in enlisting a parent, guardian, family member, or agent to act upon the client's behalf.

F. A licensee shall ensure that research or treatment that is not a professionally recognized treatment is approved by a Human Subject Review Committee before a staff member, client, or client record is involved in the research or treatment. A licensee may establish and implement a Human Subject Review Committee or may use a Human Subject Review Committee established and implemented by the Department, a regional behavioral health authority, or a state university described in A.R.S. § 15-1601. A Human Subject Review Committee established and implemented by a licensee shall:
1. Establish criteria for the approval or disapproval of research or treatment;
2. Protect, during each phase of research or treatment:
   a. Client rights;
   b. Client health, safety, and welfare;
   c. Client privacy;
   d. The confidentiality of client records and information; and
   e. Client anonymity, if applicable;
3. Ensure that oversight is provided by a medical practitioner, if research or treatment may impact a client's health or safety;
4. Inform a client of:
   a. The purpose, design, scope, and goals of the research or treatment;
   b. The full extent of the client's role in the research or treatment;
   c. Any risks to the client involved in the research or treatment; and
   d. The client's right to privacy, confidentiality, and voluntary participation;
5. Obtain documentation of a client's informed consent, completed as required by R9-20-208(E), before allowing a client to participate in research or treatment; and
6. Review research or treatment requests and approve or deny requests.

G. A licensee shall ensure that if an individual arrives at an agency and requests a behavioral health service that the agency is unable to provide, the individual is provided a referral.

R9-20-202. Required Reports

A. A licensee shall:
1. Notify the OBHL within one working day of discovering that a client has experienced any of the following:
   a. Death;
   b. Any of the following that occurred on the premises or during a licensee-sponsored activity off the premises:

i. A medication error or an adverse reaction to a medication that resulted in the client's needing immediate medical services or immediate intervention by an emergency response team or the client's medical practitioner;
ii. Suspected or alleged abuse, neglect, or exploitation of the client or a violation of the client's rights under R9-20-203(B) or (C); or
iii. A suicide attempt or a self-inflicted injury that resulted in the client's needing medical services or immediate intervention by an emergency response team;
c. Either of the following that resulted in the client's needing medical services:
i. A physical injury that occurred on the premises or during a licensee-sponsored activity off the premises; or
ii. Food poisoning possibly resulting from food provided at the agency or during a licensee-sponsored activity off the premises; or
d. An unauthorized absence from a residential agency or an inpatient treatment program;
2. Document the initial notification required in subsection (A)(1) and maintain documentation of the notification on the premises or at the administrative office for at least 12 months after the date of the notification;
3. Investigate an incident required to be reported according to subsection (A)(1) and develop a written incident report containing:
a. The agency name and license number;
b. The date and time of the incident;
c. The following information about each client involved in or affected by the incident:
i. Name;
ii. Date of admission;
iii. Age or date of birth;
iv. Current diagnosis, if the client has a diagnosis;
v. Description of the client's physical and behavioral health condition before the incident; and
vi. Description of the client's physical and behavioral health condition after the incident;
d. The location of the incident;
e. A description of the incident, including events leading up to the incident;
f. The names of individuals who observed the incident;
g. A description of the action taken by the licensee, including a list of the individuals or entities notified by the licensee and the date and time of each notification;
h. If a medical practitioner was notified, a report of the medical practitioner's examination, finding, or order;
i. A description of the action taken by the licensee to prevent a similar incident from occurring in the future;
j. The signature and professional credential or job title of the individual or individuals preparing the written incident report and the signature and professional credential of the clinical director or the clinical director's designee; and
k. The date the written incident report was signed;
4. Submit the written incident report to the OBHL within five working days after the initial notification in subsection (A)(1); and
5. Maintain a copy of the written incident report on the premises or at the administrative office for at least 12 months after the date of the written incident report.

B. A licensee:
1. Of a Level 1 psychiatric acute hospital that is certified under Title XIX of the Social Security Act, a Level 1 RTC, or a Level 1 sub-acute agency that is certified under Title XIX of the Social Security Act shall ensure that within one working day after a client's death, notification is submitted to the following entities:
a. The regional office of the Centers for Medicare and Medicaid Services;
b. The Arizona Center for Disability Law; and
c. The Arizona Health Care Cost Containment System;
2. Of a Level 1 RTC or a Level 1 sub-acute agency that is certified under Title XIX of the Social Security Act shall ensure that within one working day after the occurrence of an incident listed in subsection (A)(1)(b) or subsection (A)(1)(c)(i), notification is submitted to the following entities:
a. The Arizona Center for Disability Law; and
b. The Arizona Health Care Cost Containment System; and
3. Described in subsection (B)(1) or (B)(2) shall ensure that:
a. The notification includes:
i. Client identifying information that protects the confidentiality of the client involved;
ii. A description of the incident; and
iii. The name, street address, and telephone number of the agency; and
b. Documentation of the notification required in this subsection is maintained in the client's record.

C. A licensee shall report suspected or alleged criminal activity that occurs on the premises or during a licensee-sponsored activity off the premises to the law enforcement agency having jurisdiction.
D. A licensee shall require that a staff member, employee, intern, or volunteer immediately report suspected or alleged abuse, neglect, or exploitation or a violation of a client's rights to the administrator or clinical director or to the designee for either.
E. A licensee shall notify the OBHL within 24 hours after discovering that a client, staff member, or employee has a communicable disease listed in A.A.C. R9-6-202(A) or (B) and shall include in the notification the name of the communicable disease and the action taken by the licensee to protect the health and safety of clients, staff members, and employees, according to confidentiality requirements established by law or this Chapter.

R9-20-203. Client Rights

A. A licensee shall ensure that:
1. At the time of admission, a client and, if applicable, the client's parent, guardian, custodian, designated representative, or agent receive a written list and verbal explanation of:
   a. The client rights listed in subsection (B) and (C); and
   b. If the client is an individual who is enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, the rights contained in 9 A.A.C. 21;
2. A client or, if applicable, the client's parent, guardian, custodian, or agent acknowledges, in writing, receipt of the written list and verbal explanation required in subsection (A)(1); and
3. A client who does not speak English or who has a physical or other disability is assisted in becoming aware of client rights.

B. A licensee shall ensure that a client is afforded the rights listed in A.R.S. §§ 36-504 through 36-514.

C. A client has the following rights:
1. To be treated with dignity, respect, and consideration;
2. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment;
3. To receive treatment that:
   a. Supports and respects the client's individuality, choices, strengths, and abilities;
   b. Supports the client's personal liberty and only restricts the client's personal liberty according to a court order; by the client's consent; or as permitted in this Chapter; and
   c. Is provided in the least restrictive environment that meets the client's treatment needs;
4. Not to be prevented or impeded from exercising the client's civil rights unless the client has been adjudicated incompetent or a court of competent jurisdiction has found that the client is unable to exercise a specific right or category of rights;
5. To submit grievances to agency staff members and complaints to outside entities and other individuals without constraint or retaliation;
6. To have grievances considered by a licensee in a fair, timely, and impartial manner;
7. To seek, speak to, and be assisted by legal counsel of the client's choice, at the client's expense;
8. To receive assistance from a family member, designated representative, or other individual in understanding, protecting, or exercising the client's rights;
9. If enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, to receive assistance from human rights advocates provided by the Department or the Department's designee in understanding, protecting, or exercising the client's rights;
10. To have the client's information and records kept confidential and released only as permitted under R9-20-211(A)(3) and (B);
11. To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without consent, except:
    a. For photographing for identification and administrative purposes, as provided by A.R.S. § 36-507(2);
    b. For a client receiving treatment according to A.R.S. Title 36, Chapter 37; or
    c. For video recordings used for security purposes that are maintained only on a temporary basis;
12. To review, upon written request, the client's own record during the agency's hours of operation or at a time agreed upon by the clinical director, except as described in R9-20-211(A)(6);
13. To review the following at the agency or at the Department:
    a. This Chapter;
    b. The report of the most recent inspection of the premises conducted by the Department;
    c. A plan of correction in effect as required by the Department;
    d. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, the most recent report of inspection conducted by the nationally recognized accreditation agency; and

   e. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, a plan of correction in effect as required by the nationally recognized accreditation agency;
14. To be informed of all fees that the client is required to pay and of the agency's refund policies and procedures before receiving a behavioral health service, except for a behavioral health service provided to a client experiencing a crisis situation;
15. To consent to treatment, unless treatment is ordered by a court of competent jurisdiction, after receiving a verbal explanation of the client's condition and the proposed treatment, including the intended outcome, the nature of the proposed treatment, any procedures involved in the proposed treatment, any risks or side effects from the proposed treatment, and any alternatives to the proposed treatment;
16. To be offered or referred for the treatment specified in the client's treatment plan;
17. To receive a referral to another agency if the agency is unable to provide a behavioral health service that the client requests or that is indicated in the client's treatment plan;
18. To refuse treatment or withdraw consent to treatment unless such treatment is ordered by a court or is necessary to save the client's life or physical health;
19. To be free from:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Retaliation for submitting a complaint to the Department or another entity;
   g. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the client's treatment needs, except as established in a fee agreement signed by the client or the client's parent, guardian, custodian, or agent;
   h. Treatment that involves the denial of:
      i. Food,
      ii. The opportunity to sleep, or
      iii. The opportunity to use the toilet; and
      iv. Restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation;
20. To participate or, if applicable, to have the client's parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of the client's written treatment plan;
21. To control the client's own finances except as provided by A.R.S. § 36-507(5);
22. To participate or refuse to participate in religious activities;
23. To refuse to perform labor for an agency, except for housekeeping activities and activities to maintain health and personal hygiene;
24. To be compensated according to state and federal law for labor that primarily benefits the agency and that is not part of the client's treatment plan;
25. To participate or refuse to participate in research or experimental treatment;
26. To consent in writing, refuse to consent, or withdraw written consent to participate in research or treatment that is not a professionally recognized treatment;
27. To refuse to acknowledge gratitude to the agency through written statements, other media, or speaking engagements at public gatherings;
28. To receive behavioral health services in a smoke-free facility, although smoking may be permitted outside the facility; and
29. If receiving treatment in a residential agency or an inpatient treatment program:
   a. If assigned to share a bedroom, to be assigned according to R9-20-405(F) and, if applicable, R9-20-404(A)(4)(a);
   b. To associate with individuals of the client's choice, receive visitors, and make telephone calls during the hours established by the licensee and conspicuously posted in the facility, unless:
      i. The medical director or clinical director determines and documents a specific treatment purpose that justifies waiving this right; and
      ii. The client is informed of the reason why this right is being waived and the client's right to submit a grievance regarding this treatment decision;
   c. To privacy in correspondence, communication, visitation, financial affairs, and personal hygiene, unless:
      i. The medical director or clinical director determines and documents a specific treatment purpose that justifies waiving this right; and
      ii. The client is informed of the reason why this right is being waived and the client's right to submit a grievance regarding this treatment decision;

d. To send and receive uncensored and unopened mail, unless restricted by court order;
e. To maintain, display, and use personal belongings, including clothing, unless restricted by court order or according to A.R.S. § 36-507(5) and as documented in the client record;
f. To be provided storage space, capable of being locked, on the premises while the client receives treatment;
g. To be provided meals to meet the client's nutritional needs, with consideration for client preferences;
h. To be assisted in obtaining clean, seasonably appropriate clothing that is in good repair and selected and owned by the client;
i. To be provided access to medical services, including family planning, to maintain the client's health, safety, or welfare;
j. To have opportunities for social contact and daily social, recreational, or rehabilitative activities;
k. To be informed of the requirements necessary for the client's discharge or transfer to a less restrictive physical environment; and
l. To receive, at the time of discharge or transfer, recommendations for any treatment needed when the client is discharged.

R9-20-204. Staff Member and Employee Qualifications and Records

A. A licensee shall ensure that:
1. A staff member is at least 21 years old;
2. Except as provided in subsection (A)(3), an intern is at least 18 years old;
3. An intern in a Level 1 specialized transitional agency is at least 21 years old; and
4. A volunteer is at least 21 years old.

B. A licensee shall ensure that a behavioral health professional has the skills and knowledge necessary to:
1. Provide the behavioral health services that the agency is authorized to provide; and
2. Meet the unique needs of the client populations served by the agency, such as children, adults age 65 or older, individuals with a substance abuse problem, individuals who are seriously mentally ill, individuals who have co-occurring disorders, or individuals who may be victims or perpetrators of domestic violence.

C. A licensee shall ensure that an individual who is a certified baccalaureate social worker, certified master social worker, certified associate marriage and family therapist, or certified associate counselor according to A.R.S. Title 32, Chapter 33 is under direct supervision as defined in A.A.C. R4-6-101.

D. A licensee shall ensure that a behavioral health technician has the skills and knowledge required in subsection (F) and otherwise required in this Chapter.

E. A licensee shall ensure that a behavioral health paraprofessional hired after the effective date of this Chapter:
1. Who has six weeks of behavioral health work experience has the skills and knowledge required in subsection (F); and
2. Who does not have six weeks of behavioral health work experience:
   a. Receives six weeks of continuous on-site direction from a behavioral health professional, a behavioral health technician, or a behavioral health paraprofessional who has at least six months of behavioral health work experience; and
   b. Has the skills and knowledge required in subsection (F) after the six weeks of continuous on-site direction.

F. A licensee shall ensure that a behavioral health technician or behavioral health paraprofessional hired after the effective date of this Chapter has the skills and knowledge necessary to perform the duties that the behavioral health technician or behavioral health paraprofessional is authorized to provide and:
1. Necessary to:
   a. Protect client rights in R9-20-203;
   b. Provide treatment that promotes client dignity, independence, individuality, strengths, privacy, and choice;
   c. Recognize obvious symptoms of a mental disorder, personality disorder, or substance abuse;
   d. Provide the behavioral health services that the agency is authorized to provide and that the staff member is qualified to provide;
   e. Meet the unique needs of the client populations served by the agency or the staff member, such as children, adults age 65 or older, individuals who have substance abuse problems, individuals who are seriously mentally ill, or individuals who have co-occurring disorders;
   f. Protect and maintain the confidentiality of client records and information;
   g. Recognize and respect cultural differences;
   h. Recognize, prevent, and respond to a situation in which a client:
      i. May be a danger to self or a danger to others,
      ii. Behaves in an aggressive or destructive manner,
      iii. May be experiencing a crisis situation, or
      iv. May be experiencing a medical emergency;
   i. Read and implement a client's treatment plan;
   j. Assist a client in accessing community services and resources;

k. Record and document client information;
l. Demonstrate ethical behavior, such as by respecting staff member and client boundaries and recognizing the inappropriateness of receiving gratuities from a client;
m. Identify types of medications commonly prescribed for mental disorders, personality disorders, and substance abuse and the common side effects and adverse reactions of the medications;
n. Recognize and respond to a fire, disaster, hazard, and medical emergency; and
o. Provide the activities or behavioral health services identified in the staff member's job description or the agency's policy and procedure; and

2. That are verified:
   a. Except as provided in subsection (E)(2), before the staff member provides behavioral health services to a client;
   b. By the clinical director, a behavioral health professional, or a behavioral health technician with a combination of at least six years of education in a field related to behavioral health and full-time behavioral health work experience; and
   c. Through one or more of the following:
      i. Visual observation of the staff member interacting with another individual, such as through role playing exercises;
      ii. Verbal interaction with the staff member, such as interviewing, discussion, or question and answer; or
      iii. A written examination.

G. A licensee shall ensure that verification of each of the skills and knowledge required in subsection (F) are documented, including the:
1. Name of the staff member;
2. Date skills and knowledge were verified;
3. Method of verification used, according to subsection (F)(2)(c); and
4. Signature and professional credential or job title of the individual who verified the staff member's skills and knowledge.

H. A licensee of a residential agency or an inpatient treatment program shall ensure that:
1. Before providing behavioral health services, a staff member submits documentation of a physical examination or nursing assessment that indicates that the staff member is capable of performing the duties contained in the staff member's job description;
2. At the starting date of employment or before providing behavioral health services and every 12 months thereafter, a staff member submits one of the following as evidence of freedom from infectious pulmonary tuberculosis:
   a. A report of a negative Mantoux skin test administered within six months before the report is submitted; or
   b. If the staff member has had a positive skin test for tuberculosis, a written statement from a medical practitioner dated within six months before the statement is submitted indicating that the staff member is free from infectious pulmonary tuberculosis; and
3. If a staff member or employee has a communicable disease listed in R9-6-202(A) or (B), the staff member or employee provides written authorization from a medical practitioner before returning to work.

I. A licensee shall ensure that a personnel record is maintained for each staff member that contains:
1. The staff member's name, date of birth, home address, and home telephone number;
2. The name and telephone number of an individual to be notified in case of an emergency;
3. The starting date of employment or contract service and, if applicable, the ending date; and
4. Documentation of:
   a. The staff member's compliance with the qualifications required in this Chapter, as applicable;
   b. The staff member's compliance with the behavioral health work experience requirements in this Section;
   c. The staff member's compliance with the fingerprinting requirements in R9-20-201(A)(1)(c) or 9 A.A.C. 20, Article 13, if applicable;
   d. The performance reviews required in R9-20-201(D);
   e. The verification of the staff member's skills and knowledge required in subsection (G), if applicable, and as otherwise required in this Chapter;
   f. The clinical supervision required in R9-20-205, if applicable;
   g. The staff member's completion of the orientation required in R9-20-206(A);
   h. The staff member's completion of the training required in R9-20-206(B), if applicable;
   i. Any disciplinary action taken against the staff member;
   j. The staff member's documentation of CPR and first aid training, as required in R9-20-207(B), if applicable; and
   k. For a staff member working in a residential agency:
      i. The staff member's physical examination or nursing assessment as required in subsection (H)(1), and
      ii. The staff member's freedom from infectious pulmonary tuberculosis as required in subsection (H)(2).

J. A licensee shall ensure that a personnel record is maintained for each volunteer, intern, or employee that contains:
1. The individual's name, date of birth, home address, and home telephone number;
2. The name and telephone number of an individual to be notified in case of an emergency;
3. The starting date of employment, contract service, or volunteer service and, if applicable, the ending date;
4. For an individual working or providing volunteer services in a residential agency, documentation of the individual's freedom from infectious pulmonary tuberculosis as required in subsection (H)(2); and
5. Documentation of the individual's compliance with the fingerprinting requirements in R9-20-201(A)(1)(c) or 9 A.A.C. 20, Article 13, if applicable.

K. A licensee shall ensure that personnel records required in this Section are maintained:
1. On the premises or at the administrative office;
2. Throughout an individual's period of employment, contract service, volunteer service, or internship; and
3. For at least two years after the last date of the individual's employment, contract service, volunteer service, or internship.

R9-20-205. Clinical Supervision

A. A clinical director shall ensure that a behavioral health professional develops, implements, monitors, and complies with a written plan for clinical supervision for the agency. A written plan for clinical supervision shall:
1. Ensure that clinical supervision addresses the treatment needs of all clients, including clients who receive treatment from the agency for a short period of time, such as 14 days or less;
2. Establish criteria to determine:
   a. When clinical supervision shall be provided to a staff member on an individual basis, which shall include a requirement that a staff member involved in an incident reported under R9-20-202(A)(1) receive clinical supervision related to the incident on an individual basis; and
   b. When a staff member listed in subsection (B) is capable of providing clinical supervision;
3. Establish a process for reviewing an incident reported under R9-20-202(A)(1); and
4. Establish requirements and time-frames for documenting clinical supervision.

B. A licensee shall ensure that clinical supervision is provided by an individual who:
1. Has skills and knowledge in the behavioral health services that the agency is authorized to provide and the populations served by the agency; and
2. Is one of the following:
   a. A behavioral health professional, or
   b. A behavioral health technician with a combination of full-time behavioral health work experience and education in a field related to behavioral health totaling at least six years.

C. A licensee shall ensure that a behavioral health technician who provides clinical supervision:
1. Receives clinical supervision from a behavioral health professional according to the requirements in this Section; and
2. Has skills and knowledge in providing clinical supervision that are verified:
   a. Before the behavioral health technician provides clinical supervision;
   b. By a behavioral health professional who provides clinical supervision; and
   c. Through one or more of the following:
      i. Visual observation of the behavioral health technician interacting with another individual, such as through role playing exercises;
      ii. Verbal interaction with the behavioral health technician, such as interviewing, discussion, or question and answer; or
      iii. A written examination.

D. A licensee shall ensure that:
1. A behavioral health technician or a behavioral health paraprofessional who works full time receives at least four hours of clinical supervision in a calendar month;
2. A behavioral health technician or a behavioral health paraprofessional who works part time receives at least one hour of clinical supervision for every 40 hours worked; and
3. Clinical supervision occurs on an individual or group basis and may include clinical supervision in response to an incident, an emergency safety response, or, if applicable, debriefings that occur after restraint or seclusion.

E. A licensee shall ensure that clinical supervision includes:
1. Reviewing and discussing client behavioral health issues, behavioral health services, or records;
2. Recognizing and meeting the unique treatment needs of the clients served by the agency, such as children, adults age 65 or older, individuals who have substance abuse problems, individuals who are seriously mentally ill, or individuals who have co-occurring disorders;
3. Reviewing and discussing other topics that enhance the skills and knowledge of staff members; and
4. For a behavioral health technician providing a client with an assessment or treatment plan, determining whether an assessment or treatment plan is complete and accurate and meets the client's treatment needs.

F. A licensee shall ensure that the four hours of clinical supervision required for a behavioral health technician and a behavioral health paraprofessional is documented at least once a month, to include:
1. The date of the clinical supervision,
2. The name, signature, and professional credential or job title of the staff member receiving clinical supervision,
3. The signature and professional credential or job title of the individual providing clinical supervision and the date signed,
4. The duration of the clinical supervision,
5. A description of the topic or topics addressed in clinical supervision, as described in subsection (E),
6. Whether clinical supervision occurred on a group or individual basis, and
7. Identification or recommendation of additional training that may enhance the staff member's skills and knowledge.

R9-20-206. Orientation and Training

A. A licensee shall ensure that:
1. The clinical director develops and implements a written plan to provide staff orientation;
2. A staff member completes orientation before providing behavioral health services;
3. Orientation of a staff member includes:
   a. Reviewing:
      i. Client rights;
      ii. Agency policies and procedures necessary for the performance of the staff member's duties;
      iii. The staff member's job description;
      iv. The agency's evacuation path; and
      v. Procedures for responding to a fire, a disaster, a hazard, a medical emergency, and a client experiencing a crisis situation;
   b. Informing the staff member of the requirement to immediately report suspected or alleged abuse, neglect, or exploitation or a violation of a client's rights to the administrator or clinical director; and
   c. Identifying the location of client records and how client records and information are protected; and
4. A staff member's orientation is documented, to include:
   a. The staff member's name, signature, and professional credential or job title,
   b. The date orientation was completed,
   c. The subject or topics covered in the orientation,
   d. The duration of the orientation, and
   e. The name, signature, and professional credential or job title of the individual providing the orientation.

B. A licensee shall ensure that the clinical director:
1. Develops and implements a written staff member training plan for the agency that includes a description of the training that a behavioral health professional, behavioral health technician, or behavioral health paraprofessional needs to:
   a. Maintain current skills and knowledge;
   b. Obtain or enhance skills and knowledge in the behavioral health services the agency is authorized to provide; and
   c. Meet the unique needs of the client populations served by the agency, such as children, adults age 65 or older, individuals who have substance abuse problems, individuals who are seriously mentally ill, or individuals who have co-occurring disorders;
2. Ensures that each staff member, except for a behavioral health professional who is required by state law to complete continuing education to maintain the behavioral health professional's occupational license or certificate, completes:
   a. At least 48 hours of training during the first 12 months of full-time employment or contract service, or the equivalent amount for part-time employment or contract service, after the staff member's starting date of employment or contracted service, which may include time spent in orientation and in acquiring the skills and knowledge required in R9-20-204(F); and
   b. At least 24 hours of training every 12 months of full-time employment or contract service, or the equivalent amount for part-time employment or contract service, after the staff member's first 12 months of employment or contract service;
3. Ensures that during a staff member's first 12 months of employment or contract service, training includes the topics listed in R9-20-204(F) and other topics identified in the written staff member training plan; and
4. Ensures that a staff member's training is documented, to include:
   a. The staff member's name, signature, and professional credential or job title;
   b. The date of the training;
   c. The subject or topics covered in the training;
   d. The duration of the training; and
   e. The name, signature, and professional credential or job title of the individual providing the training.

R9-20-207. Staffing Requirements

A. A licensee shall ensure that an agency has staff members and employees to:
1. Meet the requirements in this Chapter;
2. Provide:
   a. The behavioral health services the agency is authorized to provide;
   b. The behavioral health services stated in the agency program description, as required in R9-20-201(A)(2)(c); and
   c. The treatment identified in each client's treatment plan; and
3. Ensure the health, safety, and welfare of a client:
   a. On the premises;
   b. On an agency-sponsored activity off the premises; and
   c. While the client is receiving behavioral health services or ancillary services from the licensee off the premises.

B. A licensee shall ensure that at least one staff member is present at the facility during hours of agency operation or on an outing who has current documented successful completion of first-aid and CPR training specific to the populations served by the agency, such as children or adults, that included a demonstration of the staff member's ability to perform CPR.

C. A licensee of a residential agency or inpatient treatment program shall ensure that:
1. At least one staff member is present and awake at the facility at all times when a client is on the premises,
2. At least one staff member is on-call and available to come to the agency if needed, and
3. The agency has sufficient staff members that provide general client supervision and treatment and sufficient staff members or employees to provide ancillary services to meet the scheduled and unscheduled needs of each client.

D. A licensee shall ensure that each agency has a daily staffing schedule that:
1. Indicates the date, scheduled work hours, and name of each staff member assigned to work, including on-call staff members;
2. Includes documentation of the staff members who work each day and the hours worked by each staff member; and
3. Is maintained on the premises or at the administrative office for at least 12 months after the last date on the documentation.

R9-20-208. Admission Requirements

A. A licensee may conduct a preliminary review of an individual's presenting issue and unique needs before conducting an assessment of the individual or admitting the individual into the agency. If a licensee determines, based on an individual's presenting issue and unique needs, that the individual is not appropriate to receive a behavioral health service or ancillary service at an agency, the licensee shall ensure that the individual is provided with a referral to another agency or entity. If an individual received a face-to-face preliminary review, a staff member shall provide the individual with a written referral.

B. A licensee of an agency that provides respite shall ensure that a policy and procedure is developed, implemented, and complied with that ensures that:
1. A respite admission does not cause the agency to exceed the licensed capacity identified on the agency's license,
2. A respite client meets the admission requirements in this Section,
3. A respite client receives an assessment and treatment plan for the period of time that the client is receiving respite from the agency, and
4. A respite client's treatment plan addresses how the client will be oriented to and integrated into the daily activities at the agency.

C. A licensee shall ensure that:
1. An individual is admitted into an agency based upon:
   a. The individual's presenting issue and treatment needs and the licensee's ability to provide behavioral health services and ancillary services consistent with those treatment needs;
   b. The criteria for admission contained in the agency program description, as required in R9-20-201(A)(2)(h)(i), and the licensee's policies and procedures; and
   c. According to the requirements of state and federal law and this Chapter; and
2. An individual admitted into and receiving treatment from an agency does not require from the agency:
   a. A behavioral health service or medical service that the agency is not authorized to provide,
   b. A behavioral health service or medical service that the agency's staff members are not qualified or trained to provide, or
   c. A behavioral health service or ancillary service that the agency is unable to provide.

D. A licensee shall ensure that:
1. Based upon an assessment, if an individual is not appropriate to receive a behavioral health service or ancillary service according to the criteria in subsection (C), the individual is provided with a referral to another agency or entity; and
2. If an individual received a face-to-face assessment, a staff member provides the individual with a written referral.

E. A licensee shall ensure that:
1. Except as stated in subsection (F), treatment is not provided unless consent is obtained from the client or, if applicable, the client's parent, guardian, custodian, or agent; and
2. Consent to treatment:
   a. Is obtained at the time of admission and before receiving a treatment for which consent has not yet been obtained;
   b. Is obtained after receiving a verbal explanation of the following:
      i. The specific treatment being proposed;
      ii. The intended outcome, nature, and procedures of the proposed treatment;
      iii. Any risks and side effects of the proposed treatment, including any risks of not proceeding with the proposed treatment;
      iv. The alternatives to the proposed treatment; and
      v. That consent is voluntary and may be withheld or withdrawn at any time; and
   c. Is documented by having the client sign and date an acknowledgment that the client has received the information in subsection (E)(2)(b) and consents.

F. A licensee is not required to obtain consent as described in subsection (E) from a client receiving court-ordered evaluation or court-ordered treatment or treatment in a Level 1 specialized transitional agency.

G. A licensee shall ensure that, at the time of admission, a client and, if applicable, the client's parent, guardian, custodian, designated representative, or agent are provided the following information:
1. A list of client rights;
2. An explanation of any fees that the client is required to pay;
3. A copy of the agency's refund policy and procedure;
4. The current telephone number and address of:
   a. The OBHL;
   b. The Department's Division of Behavioral Health Services;
   c. If the client is enrolled by a regional behavioral health authority as an individual who is seriously mentally ill, the human rights advocates provided by the Department or the Department's designee;
   d. The Arizona Department of Economic Security Office of Adult Protective Services, if applicable;
   e. The Arizona Department of Economic Security Office of Child Protective Services, if applicable; and
   f. The local office of the regional behavioral health authority;
5. A copy of the agency's grievance policy and procedure;
6. If the agency is a residential agency or an inpatient treatment program and has a dress code, a written description of the dress code;
7. If the agency is a residential agency or an inpatient treatment program, an explanation of whether treatment is provided in a secure facility; and
8. If the agency is a Level 1 RTC or a Level 1 sub-acute agency authorized to provide restraint or seclusion:
   a. The agency's policy for the use of restraint or seclusion, in a language that the client or the client's parent, guardian, custodian, or agent understands; and
   b. The name, telephone number, and mailing address for the Arizona Center for Disability Law.

H. A licensee shall ensure that receipt of the applicable information in subsection (G) is documented by having the client or the client's parent, guardian, custodian, or agent sign and date an acknowledgment that the client or the client's parent, guardian, custodian, or agent received the information.

R9-20-209. Assessment and Treatment Plan

A. A licensee shall develop, implement, and comply with policies and procedures for conducting an assessment that ensure that a staff member conducting an assessment:
1. Refers the client to a medical practitioner if there is evidence that the client's behavioral health issue may be related to a medical condition; and
2. Addresses a client's:
   a. Substance abuse history;
   b. Co-occurring disorder;
   c. Medical history;
   d. Legal history, such as custody, guardianship, or pending litigation;
   e. Criminal justice history;
   f. Family history; and
   g. Treatment history, court-ordered evaluation or court-ordered treatment.

B. A licensee shall ensure that:
1. A behavioral health professional or a behavioral health technician initiates an assessment of a client before treatment is initiated, and

2. A behavioral health professional reviews and approves a client assessment completed by a behavioral health technician to ensure that the assessment is complete and accurate and identifies whether the client may need medical services.

C. A licensee shall ensure that a client's assessment is completed with the participation of:
1. The client or the client's guardian or agent, if applicable;
2. If the client is a child, the client's parent, guardian, or custodian;
3. An individual requested by the client or the client's guardian or agent or, if the client is a child, by the client's parent, guardian, or custodian; and
4. Any individual required by federal or state law.

D. A licensee may use a written assessment completed by a behavioral health professional or a behavioral health technician not affiliated with the licensee's agency if:
1. The assessment was completed in compliance with this Section;
2. The assessment was completed within 12 months before the date of the client's admission to the licensee's agency;
3. A behavioral health professional at the licensee's agency reviews the written assessment and verifies the accuracy of the assessment by speaking with the individuals listed in subsection (C); and
4. The behavioral health professional at the licensee's agency updates the written assessment to include any changes to the client's condition since the assessment was completed.

E. A licensee shall ensure that, except for a client receiving behavioral health services in a crisis situation, a client's assessment is documented in the client record within seven days after completing the assessment, to include:
1. A description of the client's presenting issue;
2. An identification of the client's behavioral health symptoms and of each behavioral health issue that requires treatment;
3. A description of the medical services needed by the client, if any;
4. Recommendations for further assessment or examination of the client's needs;
5. Recommendations for treatment needed by the client;
6. Recommendations for ancillary services or other services needed by the client; and
7. The signature, professional credential or job title, and date signed of:
   a. The staff member conducting the assessment; and
   b. If the assessment was completed by a behavioral health technician, the behavioral health professional approving the assessment.

F. A licensee shall ensure that:
1. A client's assessment is reviewed and updated, as necessary:
   a. When additional information that affects the client's assessment is identified, and
   b. At least once every 12 months; and
2. A review and update of a client's assessment is documented in the client record within seven days after the review is completed.

G. A licensee shall ensure that the assessment of a client receiving behavioral health services in a crisis situation is documented in the client record:
1. Before the individual's or client's:
   a. Admission,
   b. Transfer, or
   c. Referral; and
2. To include the requirements in subsections (E)(1) through (6), the name of the behavioral health professional who verbally approved the assessment, and the date and time of the verbal approval.

H. A licensee shall ensure that policies and procedures for developing, implementing, monitoring, and updating a treatment plan are developed, implemented, and complied with.

I. A licensee shall ensure that a treatment plan is developed for each client and that the treatment plan is:
1. Based upon the client's assessment;
2. Developed before treatment is initiated, except for orders from a medical practitioner at initiation of treatment;
3. Developed by a behavioral health professional or a behavioral health technician;
4. Developed with the participation of the client or the client's guardian or agent or, if the client is a child, the client's parent, guardian, or custodian;
5. If the treatment plan was completed by a behavioral health technician, reviewed and approved by a behavioral health professional to ensure that the treatment plan is complete and accurate and meets the client's treatment needs;
6. Except for a client receiving behavioral health services in a crisis situation, documented in the client record within seven days after initiation of treatment, to include:
   a. The client's presenting issue;
   b. One or more treatment goals;

c. One or more treatment methods and the frequency of each treatment method;
d. The date when the client's treatment plan will be reviewed;
e. The method and frequency of communicating the client's progress to:
i. The client;
ii. The client's parent, guardian, custodian, agent, family member, or designated representative;
iii. The individual who coordinates behavioral health services and ancillary services for the client; and
iv. Other agencies, individuals, or entities that provide treatment to the client;
f. If a discharge date has been determined, the treatment needed after discharge;
g. The signature and date signed, or documentation of the refusal to sign, of the client or the client's guardian or agent or, if the client is a child, the client's parent, guardian, or custodian; and
h. The signature, professional credential or job title and date signed of:
i. The staff member developing the treatment plan; and
ii. If the treatment plan was completed by a behavioral health technician, the behavioral health professional approving the treatment plan; and
7. Reviewed and updated on an on-going basis:
a. According to the review date specified in the treatment plan,
b. When a treatment goal is accomplished or changes,
c. When additional information that affects the client's assessment is identified, and
d. When a client has a significant change in condition or experiences an event that affects treatment

J. A licensee shall ensure that the treatment plan to resolve or address a crisis situation is documented at the agency:
1. Before the date of the individual's or client's:
a. Admission,
b. Transfer, or
c. Referral; and
2. To include the name of the behavioral health professional who verbally approved the treatment plan and the date and time of the verbal approval.

K. A licensee shall ensure that:
1. A client's treatment is based upon the client's treatment plan;
2. When a client's treatment plan is reviewed under subsection (I)(7), a behavioral health professional or behavioral health technician reviews the client's progress in treatment and determines whether the client needs to be transferred or discharged; and
3. If a client's progress is reviewed by a behavioral health technician, the behavioral health technician's review and determinations are approved by a behavioral health professional.

R9-20-210. Discharge

A. A licensee shall ensure that a client is discharged from an agency:
1. According to the requirements of this Chapter and state and federal law;
2. According to the agency's discharge criteria contained in the agency's program description according to R9-20-201(A)(2)(h)(iv);
3. When the client's treatment goals are achieved, as documented in the client's treatment plan; or
4. When the client's behavioral health issues or treatment needs are not consistent with the behavioral health services that the agency is authorized or able to provide.

B. A licensee shall ensure that, at the time of discharge, a client receives a referral for treatment or ancillary services that the client may need after discharge.

C. A licensee shall ensure that a discharge summary:
1. Is entered into the client record within 15 days after a client's discharge;
2. Is completed by a behavioral health professional or a behavioral health technician; and
3. Includes:
a. The client's presenting issue and other behavioral health issues identified in the client's treatment plan;
b. A summary of the treatment provided to the client;
c. The client's progress in meeting treatment goals, including treatment goals that were and were not achieved;
d. The name, dosage, and frequency of each medication for the client ordered at the time of the client's discharge by a medical practitioner at the agency; and
e. A description of the disposition of the client's possessions, funds, or medications.

D. A licensee shall ensure that a client who is dependent upon a prescribed medication is offered detoxification services, opioid treatment, or a written referral to detoxification services or opioid treatment before the client is discharged from the agency if a medical practitioner for the agency will not be prescribing the medication for the client at or after discharge.

E. A licensee shall ensure that a client who is involuntarily discharged is offered or provided a written notice indicating:
1. The client's right to submit a grievance, and

2. The agency's grievance policy and procedure.

R9-20-211. Client Records

A. A licensee shall ensure that a single active client record is maintained for each client and:
1. Is protected at all times from loss, damage, or alteration;
2. Is confidential;
3. Is only released or disclosed:
   a. To a person listed in A.R.S. § 12-2294;
   b. As provided in:
      i. A.R.S. § 12-2292(B);
      ii. A.R.S. § 36-504;
      iii. A.R.S. § 36-509;
      iv. A.R.S. § 36-3283(D);
      v. 42 U.S.C. § 290dd-2 (1994 & Supplement V 1999), incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available at www.access.gpo.gov/uscode/uscmain.html and from U.S. Government Printing Office, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954; or
      vi. Another applicable federal or state law that authorizes release or disclosure; or
   c. With written permission from the client or, if applicable, the client's parent, guardian, custodian, or agent, according to subsection (B);
4. Is legible and recorded in ink or electronically recorded;
5. Contains entries that are dated and:
   a. Signed by the individual making the entry;
   b. Initialed by the individual making the entry; or
   c. Authenticated by the individual making the entry in accordance with the following:
      i. The individual who makes the entry embosses the entry with a rubber stamp or uses a computer code;
      ii. The rubber stamp or computer code is not authorized for use by another individual; and
      iii. The individual who makes the entry signs a statement that the individual is responsible for the use of the rubber stamp or the computer code;
6. Is available for review during the agency's hours of operation or at another time agreed upon by the clinical director upon written request by the client or the client's parent, guardian, custodian, or agent, if applicable, unless:
   a. For a client receiving court-ordered evaluation or court-ordered treatment, the client's physician determines that the client's review of the client record is contraindicated according to A.R.S. § 36-507(3) and documents the reason for the determination in the client record; or
   b. For a client not receiving court-ordered evaluation or court-ordered treatment, the client's physician or psychologist determines that the client's review of the client record is contraindicated based upon A.R.S. § 12-2293 and documents the reason for the determination in the client record;
7. Does not contain information about another client or individual unless the information impacts the treatment to the client;
8. Is current and accurate;
9. Is amended as follows:
   a. The information to be amended is struck out with a single line that allows the struck information to be read; and
   b. The amended entry is signed, initialed, or authenticated as described in subsection (A)(5)(c) by the individual making the amended entry;
10. Except as provided in subsection (A)(11), contains original documents and original signatures, initials, or authentication;
11. For events occurring in group counseling, may contain photocopies of original documents but with client specific treatment information added;
12. Is maintained on the premises of the behavioral health agency at which the client is admitted until the client is discharged;
13. Is available and accessible to staff members who provide behavioral health services to the client;
14. Is retained after a client's discharge:
    a. For a client who is an adult, for seven years after the date of the client's discharge, unless otherwise provided by law or this Chapter; and
    b. For a client who is a child, for seven years after the date of discharge or for at least three years after the date of the client's 18th birthday, whichever is a longer period of time; and
15. Is disposed of in a manner that protects client confidentiality.

B. A licensee shall ensure that written permission for release of a client record or information, as described in subsection (A)(3)(c), is obtained according to the following:

1. Written permission is obtained before a client record or information is released or disclosed;
2. Written permission is obtained in a language understood by the individual signing the written permission under subsection (3)(h);
3. Written permission includes:
   a. The name of the agency disclosing the client record or information;
   b. The purpose of the disclosure;
   c. The individual, agency, or entity requesting or receiving the record or information;
   d. A description of the client record or information to be released or disclosed;
   e. A statement indicating permission and understanding that permission may be revoked at any time;
   f. The date or condition when the permission expires;
   g. The date the permission was signed; and
   h. The signature of the client or the client's parent, guardian, custodian, or agent; and
4. Written permission is maintained in the client record.

C. A licensee shall ensure that a progress note is documented on the date that an event occurs. Any additional information added to the progress note is identified as a late entry.

D. A licensee shall ensure that a client record contains the following, if applicable:
1. The client's name, address, home telephone number, and date of birth;
2. The name and telephone number of:
   a. An individual to notify in case of medical emergency;
   b. The client's medical practitioner, if applicable;
   c. The individual who coordinates the client's behavioral health services or ancillary services, if applicable;
   d. The client's parent, guardian, or custodian, if applicable; or
   e. The client's agent, if applicable;
3. The date the client was admitted into the agency;
4. The following information about each referral made or received by the agency:
   a. The date of the referral;
   b. The reason for the referral; and
   c. The name of the entity, agency, or individual that the client was referred to or from;
5. Whether the client is receiving court-ordered evaluation or court-ordered treatment or is a DUI client or a client in a misdemeanor domestic violence offender treatment program;
6. If the client is receiving court-ordered evaluation or court-ordered treatment, a copy of the court order, pre-petition screening, and court-ordered evaluation as required by A.R.S. Title 36, Chapter 5;
7. Documentation of consent to treatment, as required in R9-20-208(E);
8. Documentation signed and dated by the client or, if applicable, the client's parent, guardian, custodian, or agent, indicating receipt of the information required to be provided under R9-20-208(G);
9. The client's written consent to participate in research or treatment that is not a professionally recognized treatment, according to R9-20-201(F), if applicable;
10. The assessment and updates to the assessment, as required in R9-20-209(E) and (F);
11. The treatment plan and updates and revisions to the treatment plan, as required in R9-20-209(I)(6) and (7);
12. Results from an additional examination or assessment recommended according to R9-20-209(E)(4);
13. Information or records provided by or obtained from another individual, agency, or entity regarding the client;
14. Documentation of permission to release a client record or information, as required in subsection (A)(3)(c) and (B), if applicable;
15. Documentation of requests for client records and of the resolution of those requests;
16. Documentation of the release of the client record or information from the client record to an individual or entity as described in subsection (A)(3)(a) or (b);
17. Progress notes;
18. Documentation of telephone, written, or face-to-face contact with the client or another individual that relates to the client's health, safety, welfare, or treatment;
19. Documentation of:
    a. Assistance provided to a client who does not speak English;
    b. Assistance provided to a client who has a physical or other disability, as required in R9-20-203(A)(3); and
    c. A client's known allergies or other medical condition;
20. Documentation of behavioral health services provided to the client, according to the client's treatment plan;
21. Documentation of medication services or assistance in the self-administration of medication, if applicable;
22. Medical orders, as required in this Chapter, if applicable;
23. Date of discharge and discharge summary as required in R9-20-210(C), if applicable;
24. If the client is receiving treatment in a residential agency, documentation of the client's:
    a. Orientation, as required in R9-20-401(B);

b. Screening for infectious pulmonary tuberculosis, as required in R9-20-401(A)(3); and
c. Nursing assessment or physical examination, as required in R9-20-401(A)(1) or (2), as applicable;
25. If the client is a child, the names of the individuals to whom the child may be released according to R9-20-201(E)(5); and
26. Other information or documentation required by state or federal law or this Chapter.

E. A licensee shall develop, implement, and comply with a policy and procedure to ensure the confidentiality and security of client records and client-related information, which shall include requirements that:
1. If maintained other than electronically, client records and other written client-related information be stored in a locked container or area;
2. If maintained electronically, client records and other written client-related information be protected from unauthorized access; and
3. Staff members release and discuss client-related information only as necessary for the provision of behavioral health services.

R9-20-212. Transportation

A. A licensee of an agency that uses a vehicle owned or leased by the licensee to transport a client shall ensure that:
1. The vehicle:
   a. Is safe and in good repair;
   b. Contains a first aid kit that meets the requirements in R9-20-214(I);
   c. Contains drinking water sufficient to meet the needs of each client present;
   d. Contains a working heating and air conditioning system; and
   e. Is insured according to A.R.S. Title 28, Chapter 9;
2. Documentation of vehicle insurance and a record of each maintenance or repair of the vehicle is maintained on the premises or at the administrative office;
3. A driver of the vehicle:
   a. Is 21 years of age or older;
   b. Has a valid driver license;
   c. Does not wear headphones or operate a cellular telephone while operating the vehicle;
   d. Removes the keys from the vehicle and engages the emergency brake before exiting the vehicle;
   e. Does not leave in the vehicle an unattended:
      i. Child;
      ii. Client who may be a threat to the health, safety, or welfare of the client or another individual; or
      iii. Client who is incapable of independent exit from the vehicle;
   f. Operates the vehicle safely; and
   g. Ensures the safe and hazard-free loading and unloading of clients;
4. Transportation safety is maintained as follows:
   a. Each individual in the vehicle wears a working seat belt while the vehicle is in motion;
   b. Each seat in a vehicle is securely fastened to the vehicle and provides sufficient space for a client's body; and
   c. Each individual in the vehicle is sitting in a seat while the vehicle is in motion; and
5. There is a sufficient number of staff members present to ensure each client's health, safety, and welfare.

B. A licensee of a residential agency or an inpatient treatment program shall ensure that:
1. A client receives transportation to needed medical services and to the treatment identified in the client's treatment plan or assessment; and
2. Emergency information for each client transported is maintained in the vehicle used to transport the client and includes:
   a. The client's name;
   b. Medication information, including the name, dosage, route of administration, and directions for each medication needed by the client during the anticipated duration of the transportation;
   c. The client's allergies; and
   d. The name and telephone number of the individual to notify at the agency in case of medical emergency or other emergency.

R9-20-213. Outings

A. A clinical director or designee shall ensure that:
1. An outing is consistent with the age, developmental level, physical ability, medical condition, and treatment needs of each client participating in the outing; and
2. Probable hazards, such as weather conditions, adverse client behavior, or medical situations, that may occur during the outing are identified and staff members participating in the outing are prepared and have the supplies necessary to prevent or respond to each probable hazard.

B. A licensee shall ensure that:

1. There is a sufficient number of staff members present to ensure each client's health, safety, and welfare on an outing;
2. There are at least two staff members present on an outing;
3. At least one staff member on the outing has documentation of current training in CPR and first aid according to R9-20-207(B);
4. Documentation is developed before an outing that includes:
   a. The name of each client participating in the outing;
   b. A description of the outing;
   c. The date of the outing;
   d. The anticipated departure and return times;
   e. The name, address, and, if available, telephone number of the outing destination; and
   f. The license plate number of each vehicle used to transport a client;
5. The documentation described in subsection (B)(4) is updated to include the actual departure and return times and is maintained on the premises for at least 12 months after the date of the outing;
6. Emergency information for each client participating in the outing is maintained in the vehicle used to transport the client and includes:
   a. The client's name;
   b. Medication information, including the name, dosage, route of administration, and directions for each medication needed by the client during the anticipated duration of the outing;
   c. The client's allergies; and
   d. The name and telephone number of the individual to notify at the agency in case of medical emergency or other emergency;
7. A copy of the agency's policy and procedure for outings, as required in R9-20-201(B)(1)(a), is maintained in each vehicle used on the outing; and
8. Each client participating in the outing is safely returned after the outing.

R9-20-214. Environmental Standards

A. A licensee shall ensure that:
1. An agency's facility, furnishings, and premises are:
   a. In good repair;
   b. Clean; and
   c. Free of:
      i. Odors, such as from urine or rotting food;
      ii. Insects and rodents;
      iii. Accumulations of garbage or refuse; and
      iv. Hazards;
2. A heating and cooling system maintains the facility at a temperature between 65° F and 85° F;
3. Water is available and accessible to a client at all times unless otherwise indicated in the client's treatment plan;
4. Hot water provided in an area of the facility used by a client is maintained between 90° F and 120° F;
5. Each common area of the facility has lighting sufficient to allow staff members to monitor client activity;
6. Except as described in subsection (A)(7), a toxic or other hazardous material stored by the licensee on the premises is in a labeled container in a locked area other than a food preparation or storage area, a dining area, or a medication storage area;
7. Except for medical supplies needed for a client, such as oxygen, a combustible or flammable liquid material stored by the licensee on the premises is stored in the original labeled container or a safety container in a locked area inaccessible to a client outside of the facility or in an attached garage;
8. Garbage and refuse are:
   a. Stored in covered containers or in plastic bags, and
   b. Removed from the premises at least once a week; and
9. If a pet or other animal is on the premises or at the administrative office, the pet or other animal is:
   a. Controlled to prevent endangering a client or another individual,
   b. Controlled to maintain sanitation of the premises, and
   c. Vaccinated against rabies and all other diseases that are communicable to humans and for which a vaccine is available and documentation is maintained at the facility or administrative office indicating current vaccinations.

B. A licensee shall ensure that:
1. No smoking is permitted within a facility; and
2. Smoking is permitted on the premises outside a facility only if:
   a. Signs designating smoking areas are conspicuously posted, and
   b. Smoking is prohibited in areas where combustible materials are stored or in use.

C. A licensee shall ensure that:
1. If a client has a mobility, sensory, or other physical impairment, modifications are made to the premises to ensure that the premises are accessible to and usable by the client; and
2. An agency's premises has:
   a. A waiting area with seating for clients and visitors;
   b. A room that provides privacy for a client to receive treatment or visitors; and
   c. Rooms or areas sufficient to accommodate the activities, treatment, and ancillary services stated in the agency's program description.

D. A licensee shall ensure that an agency has a bathroom that:
1. Is available for use by a client and visitors during the agency's hours of operation;
2. Provides privacy; and
3. Contains:
   a. A working sink with running water,
   b. A working toilet that flushes and has a seat,
   c. Toilet tissue,
   d. Soap for hand washing,
   e. Paper towels or a mechanical air hand dryer,
   f. Lighting, and
   g. A window that opens or another means of ventilation.

E. A licensee shall ensure that if a swimming pool is located on the premises:
1. The pool is enclosed by a wall or fence that:
   a. Is at least five feet in height;
   b. Has no vertical openings greater that four inches across;
   c. Has no horizontal openings, except as described in subsection (E)(1)(e);
   d. Is not chain-link;
   e. Does not have a space between the ground and the bottom fence rail that exceeds four inches in height;
   f. Has a self-closing, self-latching gate that opens away from the pool and that has a latch located at least five feet from the ground; and
   g. Is locked when the pool is not in use;
2. At least one staff member with CPR training, as required in R9-20-207(B), is present in the pool area when a client is in the pool area;
3. At least two staff members are present in the pool area if two or more clients are in the pool area; and
4. A life preserver is available and accessible in the pool area.

F. A licensee shall ensure that a spa that is not enclosed by a wall or fence as described in subsection (E)(1) is covered and locked when not in use.

G. A licensee shall ensure that:
1. An evacuation path is conspicuously posted on each hallway of each floor of the facility; and
2. A written disaster plan is developed and maintained on the premises.

H. A licensee shall ensure that:
1. A fire drill for staff members and clients on the premises is conducted at least once every three months on each shift;
2. Documentation of each fire drill is created and includes:
   a. The date and time of the drill;
   b. The amount of time taken for all clients and staff members to evacuate the facility;
   c. Any problems encountered in conducting the drill; and
   d. Recommendations for improvement, if applicable; and
3. Documentation of a fire drill is available for review for 12 months after the date of the drill.

I. A licensee shall ensure that a first aid kit is maintained on the premises, is accessible to staff members, and contains the following supplies in a quantity sufficient to meet the needs of all clients:
1. Adhesive bandages,
2. Gauze pads,
3. Antiseptic solution,
4. Tweezers,
5. Scissors,
6. Tape,
7. Disposable medical-grade gloves, and
8. Resealable plastic bags of at least one-gallon size.

R9-20-215. Time Out and Emergency Safety Response

A. A licensee shall ensure that a time out:

1. Takes place in an area that is unlocked, lighted, quiet, and private;
2. Is time limited and does not exceed two hours per incident or four hours per day;
3. Does not result in a client's missing a meal if the client is in time out at mealtime;
4. Includes monitoring of the client by a staff member at least once every 15 minutes to ensure the client's health, safety, and welfare and to determine if the client is ready to leave time out; and
5. Is documented in the client record, to include:
   a. The date of the time out,
   b. The reason for the time out,
   c. The duration of the time out, and
   d. The action planned and taken by the licensee to prevent the use of time out in the future.

B. A licensee shall ensure that an emergency safety response:
1. Is used only as follows:
   a. According to an agency's policy and procedure for the use of an emergency safety response;
   b. To manage a sudden, intense, or out-of-control behavior;
   c. To prevent harm to the client or others;
   d. When less restrictive methods were attempted and unsuccessful;
   e. For the shortest possible duration of time needed to bring the client's behavior under control or to prevent harm to the client or others;
   f. To ensure safety of the client and other individuals; and
   g. Without undue force;
2. Is documented, reported, and reviewed as follows:
   a. Is documented at the agency within one day of the emergency safety response including:
      i. The date and time that the emergency safety response took place;
      ii. The names of the client and staff members involved in the emergency safety response;
      iii. The specific emergency safety response that was used;
      iv. The precipitating factors that led up to the emergency safety response;
      v. The outcome of the emergency safety response, including any injuries that may have resulted from the emergency safety response and, if applicable, compliance with R9-20-202; and
      vi. If any individual was injured, the circumstances that caused the injury and a plan to prevent future injuries;
   b. If an emergency safety response occurs in a calendar month, the clinical director reviews documentation of each use of an emergency safety response that has occurred at the agency in the past month and documents the clinical director's determination of:
      i. Whether staff members are using each emergency safety response according to the agency's policy and procedure, this Chapter, and applicable federal or state laws and rules;
      ii Actions to be taken by the agency to prevent the use of emergency safety response, such as additional staff training, additional staffing, or changes to agency policy and procedure;
      iii. Whether a client is appropriately placed at the agency; and
      iv. Whether the client's treatment plan should be reviewed or revised to ensure that the client's treatment is meeting the client's treatment needs; and
   c. If an emergency safety response occurred in a calendar month, the information in subsection (B)(2)(a) through (b) is reported in writing to the OBHL within five days after the end of the calendar month and documentation is maintained at the agency that the written report was provided; and
3. Is only used by a staff member who has documentation of annual successful completion of a nationally recognized training program in crisis intervention, that includes:
   a Techniques to identify staff member and client behaviors, events, and environmental factors that may trigger the need for an emergency safety response;
   b. The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods; and
   c. The safe use of an emergency safety response, including the ability to recognize and respond to signs of physical distress in a client who is receiving an emergency safety response.

ARTICLE 3. ~~AGENCY ADMINISTRATION~~ OUTPATIENT CLINIC REQUIREMENTS

R9-20-301. ~~General Agency Administration~~ Universal Outpatient Clinic Requirements

~~**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).~~

A. A licensee shall ensure that an outpatient clinic is located:

1. In an area of a facility that is physically separated from the bedrooms, treatment rooms and common areas used by a client in a residential agency or an inpatient treatment program; or
2. In a separate facility from a residential agency or inpatient treatment program.

B. A licensee of an outpatient clinic that provides partial care to more than ten clients and serves food on the premises shall:

1. Comply with 9 A.A.C. 8, Article 1;
2. If the licensee contracts with a food establishment to prepare and deliver food to the facility, maintain on the premises or at the administrative office a copy of the food establishment's license issued according to 9 A.A.C. 8, Article 1; and
3. Ensure that if a client needs a therapeutic diet:
   a. A therapeutic diet is provided to the client; and
   b. A therapeutic diet manual with a copyright date that is no more than five years before the current date is available and accessible for use by employees or staff members who prepare food at the facility.

C. A licensee of an outpatient clinic that serves food on the premises shall ensure that:

1. Each meal served includes a variety of foods from each food group in "The Food Guide Pyramid" in Center for Nutrition Policy and Promotion, U.S. Department of Agriculture, Home and Garden Bulletin No. 252, The Food Guide Pyramid (rev. 1996), incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available from the U.S. Department of Agriculture, Center for Nutrition Policy and Promotion, 1120 20th Street, N.W., Suite 200, North Lobby, Washington, DC 20036-3475; and
2. Client input is obtained in planning menus.

R9-20-302. ~~Administrator~~ Supplemental Requirements for Counseling

~~**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.~~

A. A licensee shall ensure that counseling is:
1. Offered as described in the agency's program description in R9-20-201(A)(2)(d);
2. Provided according to the frequency and number of hours identified in the client's treatment plan;
3. Provided by a behavioral health professional or a behavioral health technician; and
4. If group counseling, limited to no more than 15 clients or, if family members participate in group counseling, no more than a total of 20 individuals, including all clients and family members.

B. A licensee shall ensure that a staff member providing counseling that addresses a specific type of behavioral health issue, such as substance abuse or crisis situations, has skills and knowledge in providing the counseling that addresses the specific type of behavioral health issue that are verified according to R9-20-204(F)(2) and documented according to R9-20-204(G)(1) through (4).

C. A licensee shall ensure that each counseling session is documented in a client record to include:
1. The date of the counseling session;
2. The amount of time spent in the counseling session;
3. The location where the counseling session occurred, if it occurred off the premises;
4. Whether the counseling was individual counseling, family counseling, or group counseling;
5. The treatment goals addressed in the counseling session;
6. The client's observed response to the counseling; and
7. The signature and professional credential or job title of the staff member who provided the counseling and the date signed.

R9-20-303. ~~Clinical or Program Director~~ Supplemental Requirements for Medication Services

~~**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 unex-~~

pectedly, 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.

A. A licensee of an agency that provides medication services shall ensure that policies and procedures are developed; approved by a pharmacist, medical practitioner, or registered nurse within six months after the effective date of this Chapter; implemented; and complied with and include:

1. A requirement that each client receive instruction in the use of the client's prescribed medication and information regarding:
   a The prescribed medication's anticipated results,
   b. The prescribed medication's potential adverse reactions,
   c. The prescribed medication's potential side effects, and
   d. Potential adverse reactions that could result from not taking the medication as prescribed;
2. Requirements for storing medication, including storage of bulk medication and, if applicable, medication that is provided off the premises;
3. Requirements for ensuring that all medication is accounted for, including bulk medication and, if applicable, medication that is provided off the premises;
4. Requirements for disposing of medication;
5. Procedures for providing medication services;
6. Procedures for preventing, responding to, and reporting a medication error, an adverse response to a medication, or a medication overdose;
7. Procedures to ensure that medication is administered to a client only as prescribed and that a client's refusal to take prescribed medication is documented in the client record;
8. A requirement that verbal orders for medication services be taken only by a nurse, unless otherwise provided by law;
9. Procedures to ensure that a client's medication regimen is reviewed by a medical practitioner and meets the client's treatment needs;
10. Procedures for documenting medication services;
11. Procedures for assisting a client in obtaining medication; and
12. Procedures for providing medication services off the premises, if applicable.

B. A licensee shall ensure that medication administration is provided only by a medical practitioner, nurse, or other individual authorized by law to provide medication administration.

C. A licensee shall ensure that medication monitoring for a client is provided as follows:

1. A nurse or medical practitioner collects:
   a. Information from the client regarding:
      i. Benefits experienced from the medication,
      ii. Any adverse reactions experienced from the medication, and
      iii. Any side effects experienced from the medication; and
   b. Medical information as required by the client's medical practitioner; and
2. A registered nurse or medical practitioner analyzes the client's information and determines whether the medication is achieving the desired effect.

D. A licensee shall ensure that medication adjustment is provided only by a medical practitioner.

E. A licensee shall ensure that the following texts are available and accessible at the facility, with copyright dates that are no more than two years before the current date:

1. A drug reference guide, such as the Physician Desk Reference; and
2. A toxicology reference book.

F. A licensee shall ensure that a record is maintained for storage and administration of a medication that is a schedule II drug listed in A.R.S. § 36-2513, schedule III drug listed in A.R.S. § 36-2514, or schedule IV drug listed in A.R.S. § 36-2515, to include:

1. The name of the medication;
2. The date and quantity of the medication received by the agency;
3. The name of the individual who ordered the medication;
4. The name of each client for whom the medication is prescribed;
5. The date, time, and dosage of each medication administration;
6. The signature and professional credential or job title of each staff member administering the medication; and
7. The amount of medication remaining in the container after each medication administration.

R9-20-304. General Personnel Requirements Repealed

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.~~

R9-20-305. ~~Notice of Conviction; Fingerprinting of Staff Members Providing Behavioral Health Services Directly to Children or to Clients in Domestic Violence Shelters~~ Repealed

~~**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).~~

R9-20-306. ~~Personnel Qualifications~~ Repealed

~~**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.~~

R9-20-307. ~~Clinical Supervision~~ Repealed

~~**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.~~

~~R9-20-308.~~ ~~Staff Development and Training Requirements~~ Repealed

~~**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.~~

R9-20-309. ~~Personnel Files~~ Repealed

~~**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.~~

R9-20-310. ~~Staffing Requirements~~ Repealed

~~**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.~~

R9-20-311. ~~Health and Safety~~ Repealed

~~**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.~~

ARTICLE 4. ~~CLIENT SERVICE REQUIREMENTS~~ RESIDENTIAL AGENCY REQUIREMENTS

R9-20-401. ~~Admission and Discharge Criteria~~ Supplemental Admission Requirements

~~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.~~

A. A licensee shall ensure that:

1. A client who is an adult receives a nursing assessment within seven days after the date of the client's admission unless medical records are provided indicating that the client has received a physical examination or a nursing assessment within the 12 months before the date of the client's admission and the medical records are reviewed and verified as complete by a registered nurse or a medical practitioner;
2. A client who is a child receives a physical examination within seven days after the date of the client's admission unless medical records are provided indicating that the client has received a physical examination within the 12 months before the date of the client's admission and the medical records are reviewed and verified as complete by a medical practitioner; and
3. A client receives a Mantoux skin test for infectious pulmonary tuberculosis within seven days after the date of the client's admission. If a client's Mantoux skin test is positive, the licensee shall ensure that the client is examined by a medical practitioner to determine whether the client is free from infectious pulmonary tuberculosis and documentation of the client's freedom from infectious pulmonary tuberculosis is maintained in the client's record.

B. A licensee of a residential agency shall ensure that a client receives orientation to the agency, within 24 hours after admission to the agency or arrival on the premises, that:
   1. Includes:
      a. An explanation of the behavioral health services the agency provides;
      b. A description of the expectations for the client's behavior and of any program rules;
      c. A tour of the premises and identification of the evacuation path;
      d. A schedule of the client's planned activities; and
      e. Introductions to staff members and employees at the facility at the time of the client's orientation; and
   2. Is documented by having the client sign and date an acknowledgment that the client has completed orientation.

R9-20-402. ~~Client Assessment~~ Supplemental Requirements for Social, Recreational, or Rehabilitative Activities

~~**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.~~

A licensee shall ensure that social, recreational, or rehabilitative activities are provided at an agency each day and are:
   1. Scheduled to fill the hours that a client is not involved in other planned or structured activities;
   2. Planned at least seven days in advance;
   3. Advertised by a notice conspicuously posted on a calendar that:
      a. Includes any substitution to an activity; and
      b. Is maintained on the premises or at the administrative office for at least six months after the last date on the calendar; and
   4. Developed based upon:
      a. Client input or, if applicable, input from a client's parent, guardian, custodian, designated representative, or agent; and
      b. The clients' ages, developmental capabilities, and treatment needs.

R9-20-403. ~~Staffing Requirements for Assessment Services~~ Supplemental Requirements for Client Funds

~~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.~~

A. A licensee shall ensure that a client's funds are managed by:
1. The client;
2. The client's parent or guardian;
3. The client's custodian;
4. The client's agent; or
5. The licensee through:
   a. A representative payee agreement established and administered as required by the Social Security Administration, or
   b. A personal funds account established and administered according to this Section.

B. A licensee shall ensure that if the licensee manages a client's money through a personal funds account, the personal funds account is only initiated after receiving a written request that:
1. Is provided voluntarily by:
   a. The client,
   b. The client's parent or guardian,
   c. The client's custodian,
   d. The client's agent, or
   e. A court of competent jurisdiction;
2. May be withdrawn at any time; and
3. Is maintained in the client record.

C. A licensee of an agency that manages client funds through personal funds accounts shall ensure that a policy and procedure is developed, implemented, and complied with for:
1. Using client funds in a personal funds account;
2. Protecting client funds in a personal funds account;
3. Investigating a grievance about the use of client funds in a personal funds account and ensuring that the grievance is investigated by an individual who does not manage a personal funds account;
4. Maintaining a record for each deposit into and withdrawal from a personal funds account; and
5. Processing each deposit into and withdrawal from a personal funds account.

D. A licensee of an agency that manages client funds through a personal funds account shall ensure that:
1. The administrator or the administrator's designee:
   a. Is responsible for each personal funds account; and
   b. Initiates, maintains, and closes a personal funds account according to a voluntary written authorization from an individual listed in subsection (B)(1);
2. No more than $250 in a client's funds is maintained at the agency;
3. A client's funds in excess of $250 are maintained in an interest-bearing bank account in which the client's funds and the accrued interest attributable to the client's funds are the property of the client;
4. A client who withdraws client funds from a personal funds account that includes funds that are maintained in an interest-bearing bank account receives the accrued interest attributable to the client's funds;
5. A bond is maintained in the amount necessary to cover all client personal funds accounts maintained at the agency;
6. A personal funds account is maintained separately from any other account at the agency;
7. A staff member, employee, intern, or volunteer who is not a family member of the client has no direct or indirect ownership or survivorship interest in a client's personal funds account;
8. Except for fees that a client is responsible to pay and is notified of according to R9-20-208(G)(2) and R9-20-201(E)(1) and (2), a client's funds in a personal funds account are not used for items, behavioral health services, or ancillary services that the agency is required to provide;
9. A separate record for each client's personal funds account:
   a. Is maintained on the premises;
   b. Includes copies of receipts for all purchases made using client funds from the personal funds account;
   c. Includes documentation of all deposits and withdrawals; and
   d. During the agency's hours of operation or at another time agreed to by the administrator or clinical director, is available for review by a client; a client's parent, guardian, or custodian; a client's agent; or an official of a court of competent jurisdiction;

10. A withdrawal from a client's personal funds account:
    a. Is made only with written authorization from the client; the client's parent, guardian, or custodian; the client's agent; or an official of a court of competent jurisdiction;
    b. Is only made for the use and benefit of the client;
    c. Is not made for the purpose of enabling a client to purchase something that would place the client or another individual in immediate danger; and
    d. Is immediately documented in the client's personal funds account record, to include:
        i. The date of the withdrawal;
        ii. The amount of the withdrawal;
        iii. The name of the individual or entity requesting or authorizing the withdrawal;
        iv. The purpose of the withdrawal; and
        v. The name, signature, and professional credential or job title of the administrator or the administrator's designee who provided the funds withdrawn to the client;
11. A copy of a client's personal funds account record is provided to a client; the client's parent, guardian, or custodian; the client's agent; or an official of a court of competent jurisdiction at least once every three months, unless otherwise provided by law;
12. Documentation is made each time that a copy of a client's personal funds account record is provided as described in subsection (D)(11), to include:
    a. The name of the individual or entity to whom the record was provided,
    b. The name of the individual providing the record, and
    c. The date that the record was provided; and
13. At the time of a client's discharge, the balance of the client's funds in the client's personal funds account and a copy of the client's personal funds account record are provided to the client; the client's parent, guardian, or custodian; the client's agent; or an official of a court of competent jurisdiction; or as otherwise provided by law.

R9-20-404. ~~Treatment or Services Planning~~ Supplemental Requirements for an Agency that Provides Behavioral Health Services to Children

~~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.~~

A. A licensee shall ensure that:
1. The telephone number and address of Arizona Department of Economic Security Office of Child Protective Services is conspicuously posted and provided to the client's parent, guardian, or custodian according to the requirements in R9-20-208(G)(4)(e);
2. A child does not receive any of the following from other children at the agency:
   a. Threats,
   b. Ridicule,
   c. Verbal harassment,
   d. Punishment, or
   e. Abuse by other children;
3. A child does not receive punishment that involves the infliction of pain or injury to the body of the child;
4. A client who is a child does not:
   a. Share a bedroom, indoor common area, dining area, outdoor area, or other area where behavioral health services or activities are provided with a client age 18 or older, unless the client age 18 or older is a client described under subsection (B); or
   b. Interact with a client who is age 18 or older, unless the client age 18 or older is a client described under subsection (B);
5. A child older than three years of age does not sleep in a crib;
6. Clean and hazard-free toys, educational materials, and sports equipment are available and accessible to children on the premises in a quantity sufficient to meet each child's needs and are appropriate to each client's age, developmental level, and treatment needs;
7. The living areas of the facility are decorated in a manner appropriate to the ages of the children served at the agency;
8. A child's educational needs are met, including providing or arranging for transportation, if a child is out of school and receiving treatment for seven days or more:
   a. By establishing and maintaining an educational component, approved in writing by the Arizona Department of Education; or
   b. As arranged and documented by the licensee through the local school district; and
9. The immunization requirements in 9 A.A.C. 6, Article 7 are met, if applicable.

B. A licensee may continue to provide behavioral health services to a client who is age 18 or older:
1. If the client was admitted to the agency before the client's 18th birthday and is completing high school or a high school equivalency diploma or is participating in a job training program; or
2. Through the last day of the month of the client's 18th birthday.

R9-20-405. ~~Requirements for Client Recordkeeping~~ Environmental Standards

~~**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.~~

A. A licensee of a residential agency shall ensure that the premises have:
1. An indoor common area, that is not used as a sleeping area, and that has:
   a. A working telephone that allows a client to make a private telephone call;
   b. A distortion-free mirror;
   c. A current calendar and an accurate clock;
   d. A variety of books, current magazines and newspapers, and arts and crafts supplies appropriate to the age, educational, cultural, and recreational needs of clients;
   e. A working television and access to a radio; and
   f. Space sufficient to accommodate the social and recreational needs of clients and to allow private conversations and group activities;
2. A dining room or dining area that:
   a. Is lighted and ventilated,
   b. Contains tables and seats, and
   c. Is not used as a sleeping area;
3. For every six clients, at least one working toilet that flushes and one sink with running water;
4. For every eight clients, at least one working bathtub or shower, with a slip resistant surface;

5. An individual storage space, capable of being locked, for use by each client according to the agency's policy and procedure; and
6. An outdoor area that:
   a. Is accessible to clients,
   b. Has sufficient space to accommodate the social and recreational needs of clients, and
   c. Has shaded and unshaded areas.

B. A licensee of a residential agency shall ensure that a client's sleeping area is in a bedroom that:
1. Meets one of the following:
   a. Is a private bedroom that contains at least 60 square feet of floor space, not including the closet; or
   b. Is a shared bedroom that:
      i. Is shared by no more than four individuals;
      ii. Except as provided in subsection (C), contains at least 60 square feet of floor space, not including a closet, for each individual occupying the bedroom; and
      iii. Provides at least three feet of space between beds;
2. For an agency licensed after the effective date of this Chapter, has walls from floor to ceiling;
3. Contains a door that opens into a hallway, common area, or the outside;
4. Is constructed and furnished to provide unimpeded access to the door;
5. Is not used as a passageway to another bedroom or a bathroom unless the bathroom is for the exclusive use of an individual occupying the bedroom;
6. Contains the following for each client:
   a. An individual storage space, such as a dresser or chest;
   b. A table or other surface;
   c. A closet, wardrobe, or equivalent space for hanging clothes;
   d. Except for a child who sleeps in a crib as permitted in R9-20-404(A)(5), a bed that:
      i. Consists of at least a mattress and frame;
      ii. Is in good repair, clean, and free of odors and stains; and
      iii. Is at least 36 inches wide and 72 inches long; and
   e. A pillow and linens that are clean, free of odors, and in good repair, including:
      i. A mattress pad;
      ii. A top sheet and a bottom sheet that are large enough to tuck under the mattress;
      iii. A pillow case;
      iv. A waterproof mattress cover, if needed; and
      v. A blanket or bedspread sufficient to ensure the client's warmth; and
7. Contains:
   a. Lighting sufficient for a client to read;
   b. Windows or doors with adjustable window or door covers that provide client privacy, if applicable; and
   c. To provide safe egress in an emergency, a working door to the outside or an openable window to the outside, unless the facility contains an automatic sprinkler system as required in R9-20-406(C)(3)(b), that is no higher than 20 feet above grade and that:
      i. Meets the fire safety requirements of the local jurisdiction;
      ii. Has no dimension less than 20 inches, has an area of at least 720 square inches, and has a window sill that is no more than 44 inches off the floor; or
      iii. Is large enough, accessible to a client, and within the capability of the client to egress in an emergency.

C. If a licensee's agency was licensed before the effective date of this Chapter with a shared bedroom containing at least 50 square feet of floor space, not including a closet, for each individual occupying the room, the licensee may operate the agency with a shared bedroom containing at least 50 square feet of floor space, not including a closet, for each individual occupying the room.

D. A licensee shall ensure that:
1. The supply of hot water is sufficient to meet:
   a. Each client's daily personal hygiene needs; and
   b. The laundry, cleaning, and sanitation requirements in this Chapter;
2. Clean linens and bath towels are provided to a client as needed and at least once every seven days;
3. One of the following is available to ensure that client clothing can be cleaned:
   a. A working washing machine and dryer on the premises,
   b. An agency-provided process for cleaning clothing, or
   c. An agency-provided process for transporting a client to a building with washing machines and dryers that a client can use; and
4. Soiled linen and clothing stored by the licensee are in covered containers or closed plastic bags away from a food preparation or food storage area or a dining area.

E. A licensee shall ensure that:
1. Except for an agency located in a correctional facility, a client is not locked into a bedroom; and
2. If a client's bedroom is capable of being locked from the inside, a staff member has a key that allows access to the bedroom at all times.

F. A licensee shall ensure that clients are assigned to a bedroom:
1. As required in R9-20-404(A)(4)(a), if applicable;
2. To ensure client health, safety, and welfare; and
3. After considering a client's:
   a. Age;
   b. Gender;
   c. Developmental level;
   d. Behavioral health issues;
   e. Treatment needs; and
   f. Need for group support, independence, and privacy.

R9-20-406. ~~**Client Records for Non-emergency Services**~~ **Fire Safety Standards**

~~**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.~~

A. A licensee of a residential agency shall ensure that a fire inspection is conducted at least every 12 months by the local fire department, the Office of the State Fire Marshal, or a designee of the Office of the State Fire Marshal.

B. A licensee of a residential agency shall ensure that:
1. The agency address is posted on a contrasting background and is visible from the street;
2. A battery operated smoke detector is:
   a. Installed in each:
      i. Bedroom,
      ii. Hallway adjacent to a bedroom,
      iii. Utility room, and
      iv. Room or hallway adjacent to a kitchen; and
   b. In working order;
3. There are at least two means of egress from each bedroom;
4. A multipurpose fire extinguisher with at least a 2A10BC rating is hung on wall brackets with the top of the extinguisher handhold located less than five feet above the floor as follows:
   a. In the kitchen; and
   b. One fire extinguisher for every 3,000 square feet in the facility, not including the fire extinguisher in the kitchen;
5. An exit sign is posted above each door to the outside;
6. No extension cord is used in place of permanent wiring;
7. If an extension cord is used on a temporary basis, an extension cord does not exceed seven feet in length; is not fastened to a wall, fixture, floor, or ceiling; and is not placed under a rug;
8. An electrical outlet:
   a. Is not used beyond its rate of capacity; and
   b. Has a safety cover placed in each receptacle opening that is not in use;
9. No electrical cord in use is spliced or has tears or exposed wires;
10. Circuit breakers or fuses are labeled;
11. A space heater:
    a. Is labeled as acceptable by a nationally recognized testing laboratory, such as Underwriters Laboratory, Factory Mutual, or American Gas Association;
    b. Does not use kerosene or other flammable liquid; and
    c. Is placed away from a trash can, curtain, towel, or other material that may create a hazard;
12. A fireplace opening is protected by a screen that prevents sparks from leaving the fireplace;
13. The cooking range contains a hood, grease filter, and fan that are free of grease buildup;
14. No flammable liquid or material is stored near a water heater or other heat producing appliance;
15. All walls and ceilings are intact; and
16. A door separating the facility from an attached garage, carport, or storage room is of solid core construction.

C. A licensee of a residential agency shall ensure that a facility meets the fire safety requirements of the local jurisdiction and one of the following, as applicable:
1. If licensed for three or fewer clients, meets the requirements in subsections (A) and (B);
2. If licensed for between four and eight clients who are able to evacuate the facility in three minutes or less, has a fire alarm system, installed according to NFPA 72: National Fire Alarm Code (1999), incorporated by reference in R9-1-412(A)(4), with a fire alarm control panel that includes:
   a. A manual-pull fire alarm system,
   b. Automatic occupancy notification,
   c. A smoke or fire detection system, and
   d. Notification of a local emergency response team;

3. If licensed for between four and eight clients who are unable to evacuate the facility in three minutes or less, has at least one of the following:
   a. A fire alarm system that complies with subsection (C)(2) and at least two staff members present at the facility at all times; or
   b. An automatic sprinkler system installed according to the applicable standard incorporated by reference in R9-1-412(A)(4):
      i. NFPA 13: Installation of Sprinkler Systems (1999),
      ii. NFPA 13D: Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes (1999), or
      iii. NFPA 13R: Standard for Installation of Sprinkler Systems in Residential Occupancies Up to and Including Four Stories in Height (1999);
4. If licensed for nine or more clients:
   a. Has an automatic sprinkler system that complies with subsection (C)(3)(b); or
   b. If a licensee's agency was licensed before the effective date of this Chapter without an automatic sprinkler system, meets the requirements in subsection (C)(2); or
5. If a secure facility, has an automatic sprinkler system that complies with subsection (C)(3)(b).

R9-20-407. ~~Client Record Requirements for Emergency Services~~ Food Service Requirements

~~**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.~~

A. A licensee of an agency that provides behavioral health services to more than 10 clients and serves food on the premises shall:
1. Comply with 9 A.A.C. 8, Article 1; and
2. If the licensee contracts with a food establishment to prepare and deliver food to the facility, maintain on the premises or at the administrative office a copy of the food establishment's license issued according to 9 A.A.C. 8, Article 1.

B. A licensee shall ensure that:
1. Three meals a day are served with not more than a 14-hour time span between the evening meal and the morning meal;
2. At least one snack a day is available to clients;
3. A client's daily nutritional needs are met based upon the client's age, health needs, and, if applicable, prescribed therapeutic diet;
4. Each meal or snack is served according to a preplanned menu;
5. Each meal provides a variety of foods from each food group in the Food Guide Pyramid incorporated by reference in R9-20-301(C)(1);
6. Menus are developed with consideration for client food preferences; eating habits; customs; health needs; appetites; and religious, cultural, and ethnic backgrounds;
7. Menus are:
   a. Prepared at least one week before the date food is served;
   b. Dated and conspicuously posted, reflecting any substitutions made to the menu;

c. Approved by a registered dietician at least once every 12 months; and
d. Maintained on the premises for at least six months after the date on the menu;

8. Documentation of the dietician's review is maintained at the facility or administrative office for at least two years after the date of the review;
9. At least a one-day supply of perishable food and at least a three-day supply of non-perishable food is maintained on the premises; and
10. If a client needs a therapeutic diet:
    a. A therapeutic diet is provided to the client; and
    b. A therapeutic diet manual with a copyright date that is no more than five years before the current date is available and accessible for use by employees or staff members who prepare food at the facility.

C. A licensee shall ensure that:
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 commercial sources;
4. If canned food is used, only commercially canned food is used;
5. Foods requiring refrigeration are maintained at 41° F or below;
6. Food is cooked according to the requirements in §§ 3-401.11, 3-401.12, and 3-401.13 and reheated according to the requirements in § 3-403.11 of the U.S. Food and Drug Administration publication, Food Code: 1999 Recommendations of the U.S. Public Health Service, Food and Drug Administration (1999), as modified and incorporated by reference in A.A.C. R9-8-107;
7. Food service is provided by an individual who:
    a. Is not infected with a communicable disease listed in R9-6-202(A) or (B) that may be transmitted by food handling;
    b. Washes the individual's hands and arms with soap and warm water:
        i. Before handling food,
        ii. After smoking,
        iii. After using the toilet, and
        iv. As often as necessary to remove soil and contamination; and
    c. Maintains or restrains the individual's hair to ensure that food and food-contact surfaces do not come in contact with the individual's hair;
8. A refrigerator contains a thermometer, accurate to ± 3° F;
9. Raw fruits and raw vegetables are rinsed with water before being cooked or served;
10. Food that has been opened or removed from its original container is stored in a dated covered container, a minimum of four inches off the floor, and protected from splash and other contamination;
11. Frozen foods are maintained in a frozen state;
12. Tableware and eating utensils are provided and are clean and in good repair;
13. Food preparation, storage, and service areas are clean, in good repair, and free of insects or rodents;
14. Food preparation equipment and food-contact surfaces are clean and in good repair; and
15. Second servings of a meal or snack are available to a client at meal or snack time, unless otherwise indicated in the client's treatment plan or the client record.

R9-20-408. ~~Medication Control~~ Assistance in the Self-Administration of Medication

~~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 facilities 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.~~

A. A licensee shall ensure that a client who requires assistance in the self-administration of medication receives assistance in the self-administration of medication, which may include one or more of the following:
1. Storage of the client's medication;
2. A reminder when it is time to take a medication;
3. Verification that the medication is taken as directed by the client's medical practitioner by:
   a. Confirming that a medication is being taken by the client for whom it is prescribed;
   b. Checking the dosage against the label on the container; and
   c. Confirming that the client is taking the medication as directed;
4. Opening of the medication container for the client; or
5. Observation of the client while the client removes the medication from the container or takes the medication.

B. A licensee of an agency that provides assistance in the self-administration of medication shall ensure that policies and procedures are developed; approved by a medical practitioner, pharmacist, or registered nurse; implemented; and complied with and include:
1. A requirement that each client receive instruction in the use of the prescribed medication and information regarding:
   a. The prescribed medication's:
      i. Anticipated results,
      ii. Potential adverse reactions, and
      iii. Potential side effects; and
   b. Potential adverse reactions that could result from not taking the medication as prescribed;
2. Procedures for:
   a. Storage of medication;
   b. Informing a client when medication should be taken;
   c. Ensuring that a client takes only medication prescribed for the client and that medication is taken as directed;
   d. Observing a client taking medication;
   e. Preventing, responding to, and reporting a medication error, adverse reaction to medication, or medication overdose;
   f. Disposing of medication;
   g. Assisting a client in obtaining medication and ensuring that a client does not run out of medication; and
   h. Documenting the instruction provided in subsection (B)(1);
3. A list of the staff members authorized to assist a client in self-administration of medication and to have access to a client's medication;
4. A requirement that a client's medication regimen:
   a. Be reviewed by a registered nurse or medical practitioner according to the client's treatment needs, and
   b. Meet the client's treatment needs; and
5. A requirement that each instance of assistance in the self-administration of medication be documented.

C. A licensee of an agency that provides assistance in the self-administration of medication shall ensure that:

1. Assistance in the self-administration of medication is provided only by:
   a. A medical practitioner;
   b. A nurse; or
   c. A staff member who has the following skills and knowledge before providing assistance in the self-administration of medication to a client and that are verified by a pharmacist, medical practitioner, or registered nurse according to the requirements in R9-20-204(F)(2)(c) and documented according to R9-20-204(G)(1) through (4), although training to obtain skills and knowledge may be obtained from another agency, entity or staff member:
      i. Knowledge of the medications commonly prescribed for clients with behavioral health issues treated by the agency;
      ii. Knowledge of the common benefits, side effects, and adverse reactions of those medications;
      iii. Knowledge of the signs, symptoms, or circumstances indicating that a client should not take a medication and of who to contact to review and address the client's situation;
      iv. Knowledge of the differences between assisting in the self-administration of medication and medication administration; v.Skill in assisting in the self-administration of medication;
      vi. Knowledge of the medical terminology used in assisting in the self-administration of medication;
      vii. Knowledge of the signs, symptoms, and indicators of toxicity or overdose and skill in identifying the signs, symptoms, and indicators of toxicity or overdose;
      viii. Skill in responding to a medication error or medical emergency; and
      ix. Skill in documenting assistance in the self-administration of medication;
2. A staff member qualified according to subsection (C)(1) is present at the facility at all times when a client who needs assistance in the self-administration of medication is present at the facility; and
3. A staff member who is not a medical practitioner or nurse receives training in the items listed in subsection (C)(1)(c) from another agency, entity or staff member at least once every 12 months according to R9-20-206(B)(2) and that the training is documented according to R9-20-206(B)(4).

D. A licensee shall ensure that if a client receives assistance in the self-administration of injectable medication, the client:
1. Has written authorization from a medical practitioner;
2. Receives instruction from a nurse or medical practitioner in administering the injectable medication and demonstrates to the nurse or medical practitioner that the client is capable of administering the injectable medication; and
3. Disposes of used syringes, vials, and testing materials in a manner that protects the health and safety of the client and other individuals.

E. A licensee of an agency that provides assistance in the self-administration of medication shall ensure that a client's medication regimen is reviewed to determine if the client's medication regimen is meeting the client's treatment needs:
1. By a registered nurse or medical practitioner, and
2. According to the timeline determined by the client and the client's medical practitioner.

F. A licensee of an agency that provides assistance in the self-administration of medication shall ensure that a medication error or a client's adverse reaction to a medication is immediately reported to the clinical director or the clinical director's designee and recorded in the client record.

G. A licensee of an agency that provides assistance in the self-administration of medication shall ensure that the following texts, with copyright dates that are no more than two years before the current date, are available and accessible to a staff member assisting in the self-administration of medication at the facility or off the premises:
1. A drug reference guide, such as the Physician Desk Reference; and
2. A toxicology reference book.

H. A licensee of an agency that provides assistance in the self-administration of medication shall ensure that a client's medication:
1. Is stored in one of the following containers:
   a. An original labeled container that indicates:
      i. The client's name;
      ii. The name of the medication, the dosage, and directions for taking the medication;
      iii. The name of the individual prescribing the medication; and
      iv. The date that the medication was prescribed; or
   b. In a medication organizer that:
      i. May be prepared up to one week in advance;
      ii. States the client's name and the date prepared;
      iii. Is prepared according to a medical practitioner's orders; and
      iv. Is prepared by a medical practitioner; a nurse; a client or the client's parent, guardian, family member, custodian, or agent with observation from a medical practitioner, nurse, or staff member qualified according to subsection (C)(1); or another individual authorized by state law;

2. Is stored in a locked container, cabinet, or area that is inaccessible to a client and that complies with the medication manufacturer's recommendations;
3. While unlocked, is not left unattended by a staff member; and
4. If medication for other than oral administration, is stored separately from medication for oral administration.

I. A licensee of an agency that provides assistance in the self-administration of medication shall ensure that a staff member qualified according to subsection (C)(1) conducts an inspection of the medication storage area or areas at least once every three months to ensure compliance with this Section and documents the results of the inspection, to include:
1. The name of the staff member conducting the inspection,
2. The date of the inspection,
3. The area or areas inspected,
4. Whether medication is stored according to the requirements in this Section,
5. Whether medication is disposed of according to the requirements in this Section, and
6. Any action taken to ensure compliance with the requirements in this Section.

J. A licensee of an agency that provides assistance in the self-administration of medication shall ensure that:
1. Medication is disposed of when:
   a. The medication has expired, according to the date on the medication container label;
   b. The label on the medication container is missing or illegible;
   c. The client's medical practitioner orders that the client discontinue use of the medication;
   d. The client's medical practitioner orders that the client's medication not be released to the client at the time of the client's discharge or transfer; and
   e. When required by state or federal law or the agency's policy and procedure;
2. Medication is disposed of by at least two staff members qualified according to subsection (C)(1); and
3. Medication disposal is documented in the client record, to include:
   a. The date of disposal,
   b. The method of disposal, and
   c. The name, signature, and professional credential or job title of the staff members disposing of the medication and the date signed.

K. A licensee of an agency that provides assistance in the self-administration of medication shall ensure that a separate medication record is maintained for each client that:
1. Is current and accurate;
2. Documents each instance when a client received assistance in the self-administration of medication;
3. Is maintained at the agency where the client receives treatment; and
4. Contains the following:
   a. The name of the client;
   b. The name of the medication and dosage and directions for taking the medication;
   c. The name of the medical practitioner who prescribed the medication;
   d. The date and time the medication was taken by the client;
   e. If the assistance in the self-administration of medication occurred off the premises, the location where it occurred;
   f. The observations of the staff member, if applicable;
   g. The signature or initials and professional credential or job title of the staff member providing assistance in the self-administration of medication; and
   h. The signature or initials of the client receiving assistance in the self-administration of medication.

L. A licensee of an agency that provides assistance in the self-administration of medication shall ensure that a record is maintained for storage and administration of a medication that is a schedule II drug listed in A.R.S. § 36-2513, a schedule III drug listed in A.R.S. § 36-2514, or a schedule IV drug listed in A.R.S. § 36-2515, to include:
1. The name of the medication;
2. The date and quantity of the medication received by the agency;
3. The name of the individual who ordered the medication;
4. The name of each client for whom the medication is prescribed;
5. The date, time, and dosage of each medication administration;
6. The signature and professional credential or job title of each staff member assisting in the self-administration of the medication; and
7. The amount of medication remaining in the container after each self-administration of medication.

R9-20-409. ~~Initial Emergency Care~~ Supplemental Requirements for a Level 2 Behavioral Health Residential Agency

~~**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.~~

A licensee of a Level 2 behavioral health residential agency shall ensure that:

1. The agency has a written agreement with a behavioral health medical practitioner and a registered nurse to provide treatment as needed;
2. The written agreement described in subsection (1) is maintained on the premises or at the administrative office;
3. A behavioral health professional is present at the facility or on-call at all times;
4. A behavioral health professional is present at the facility and available to see clients at least once a week and sees and interacts with each client at least once a month;
5. Progress notes are written in a client record at least once a day; and
6. A client receives:
   a. Observation, assistance, or supervision in activities to maintain health, safety, personal care or hygiene, or independence in home making activities; and
   b. Age-appropriate training or skill building in communication, the development and maintenance of productive interpersonal relationships, and occupational or recreational activities intended to prepare a client to live independently or to enhance a client's independence.

R9-20-410. ~~Supplemental Requirements for Agencies Providing Services to Children~~ Supplemental Requirements for a Level 3 Behavioral Health Residential Agency

~~**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.~~

A licensee of a Level 3 behavioral health residential agency shall ensure that:

1. The agency has a written agreement with a behavioral health professional and a registered nurse to provide treatment as needed;
2. The agreement described in subsection (1) is maintained on the premises or at the administrative office;
3. Progress notes are written in a client record:
   a. At least once a day for the first seven days after admission, and
   b. At least once a week thereafter; and
4. A client receives:
   a. Observation, assistance, or supervision in activities to maintain health, safety, personal care or hygiene, or independence in home making activities; and
   b. Age-appropriate training or skill building in communication, the development and maintenance of productive interpersonal relationships, and occupational or recreational activities intended to prepare a client to live independently or to enhance a client's independence.

R9-20-411. **~~Food Services~~** **<u>Repealed</u>**

~~**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.~~

R9-20-412. ~~Pets and Domestic Animals~~ Repealed

~~**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.~~

R9-20-413. ~~Outings and Transportation~~ Repealed

~~**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.~~

ARTICLE 5. ~~ENVIRONMENT; PHYSICAL PLANT; SWIMMING POOLS~~ INPATIENT TREATMENT PROGRAM REQUIREMENTS

R9-20-501. ~~Agency Environment~~ Universal Inpatient Treatment Program Requirements

~~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.~~

A. A licensee of an inpatient treatment program shall designate in writing a medical director who is:
1. A psychiatrist or a physician with behavioral health work experience, and
2. In charge of medical services at the agency.

B. A licensee of an inpatient treatment program shall ensure that a behavioral health medical practitioner is present at the facility or on-call at all times.

C. A licensee of an inpatient treatment program shall ensure that:
1. If a client requires medical services that the agency is not authorized or able to provide, a staff member provides transportation or arranges for the client to be transported to a hospital or another health care institution where the medical services can be provided;
2. The licensee has a written agreement with a hospital in or near the community where the agency is located to provide medical services for clients who require medical services that the agency is not authorized or able to provide; and
3. The written agreement described in subsection (C)(2) is maintained on the premises or at the administrative office.

R9-20-502. ~~Indoor Environmental Requirements for Level I, II, and III Behavioral Health Facilities~~ Supplemental Requirements for a Level 1 Psychiatric Acute Hospital

~~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.~~

A. A licensee of a Level 1 psychiatric acute hospital shall ensure compliance with the following:

1. The requirements for a general hospital, rural general hospital, or special hospital contained in 9 A.A.C. 10, Article 2, unless:
   a. The agency was licensed as a Level 1 psychiatric acute care behavioral health facility before the effective date of this Chapter; and
   b. The agency is not certified under Title XIX of the Social Security Act;
2. If the agency is certified under Title XIX of the Social Security Act, as verified by the Department:
   a. 42 CFR 456.160 (2000), incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available from Government Institutes Division, 4 Research Place, Rockville, MD 20850;
   b. 42 CFR 441.102 (2000) or 42 CFR 456.180 through 456.181 (2000), incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available from Government Institutes Division, 4 Research Place, Rockville, MD 20850;
   c. 42 CFR 456.200 through 456.213 (2000) and 42 CFR 482.30 (2000), incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available from Government Institutes Division, 4 Research Place, Rockville, MD 20850;
   d. 42 CFR 456.170 through 456.171(2000), incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available from Government Institutes Division, 4 Research Place, Rockville, MD 20850;
   e. 42 CFR 456.231 through 456.238 (2000), incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available from Government Institutes Division, 4 Research Place, Rockville, MD 20850;
   f. 42 CFR 456.241 through 456.245 (2000), incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available from Government Institutes Division, 4 Research Place, Rockville, MD 20850;
   g. 42 CFR 456, Subpart J (2000), incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available from Government Institutes Division, 4 Research Place, Rockville, MD 20850;
   h. 42 CFR 482.13(f) (2000), incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available from Government Institutes Division, 4 Research Place, Rockville, MD 20850; and
   i. 42 CFR 482.61 and 482.62 (2000), incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available from Government Institutes Division, 4 Research Place, Rockville, MD 20850;
3. If the agency is certified to receive funds under Title XIX of the Social Security Act and provides treatment to an individual under the age of 21, the following:
   a. 42 CFR 441.150 and 441.152 through 441.156 (2000), incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available from Government Institutes Division, 4 Research Place, Rockville, MD 20850; and
   b. CFR 441.151, as published in 66 FR 7148 (2001) and amended in 66 FR 15800 (2001), incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available from U.S. Government Printing Office, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954;
4. R9-20-401;
5. R9-20-402;
6. R9-20-403; and
7. R9-20-405.

B. A licensee of a Level 1 psychiatric acute hospital shall ensure that a behavioral health technician is available at all times to admit an individual to the agency.

C. A licensee of a Level 1 psychiatric acute hospital shall ensure that:
1. A fire inspection is conducted by the local fire department having jurisdiction or the Office of the State Fire Marshal according to the requirements of the local jurisdiction;
2. The most recent fire inspection report and documentation of any corrections stated in the inspection report are maintained on the premises or at the administrative office; and
3. The facility meets the fire safety requirements of the local jurisdiction and has:
   a. A fire alarm system, installed according to NFPA 72: National Fire Alarm Code (1999), incorporated by reference in R9-1-412(A)(4), with a fire alarm control panel that includes:
      i. A manual-pull fire alarm system,
      ii. Automatic occupancy notification,
      iii. A smoke or fire detection system, and

iv. Notification of a local emergency response team; and
b. An automatic sprinkler system that:
i. Is installed as required in R9-20-406(C)(3)(b);
ii. Has a water flow device; and
iii. Has all control valve tampers tied into the fire alarm control panel.

R9-20-503. ~~Environmental Cleanliness and Sanitation for Level I, II, and III Behavioral Health Facilities~~ Supplemental Requirements for Crisis Services

~~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.~~

A. A licensee of an agency that provides crisis services shall ensure that:
1. Policies and procedures are developed, implemented, and complied with for providing crisis services and ensuring that a staff member providing crisis services has skills and knowledge in providing crisis services; and
2. Crisis services are available at all times.

B. A licensee of an agency that provides crisis services shall ensure that:
1. A psychiatrist or a physician with behavioral health work experience is present at the facility or on-call at all times;
2. A registered nurse is present at the facility at all times; and
3. A staff member who provides crisis services has skills and knowledge in providing crisis services that are verified according to R9-20-204(F)(2) and documented according to R9-20-204(G)(1) through (4).

C. A licensee of an agency that provides crisis services shall ensure that:
1. An individual who arrives at the agency and is in need of immediate medical services is examined by a physician or a registered nurse as soon as possible and is admitted to the agency or transferred to an entity capable of meeting the individual's immediate medical needs;
2. Within 24 hours after an individual has arrived at the agency, a physician determines whether the individual will be:
a. Admitted to the agency for treatment,
b. Transferred to another entity capable of meeting the individual's needs, or
c. Provided a referral to another entity capable of meeting the individual's needs; and
3. A client who, in the judgment of a physician or registered nurse, does not need immediate medical services receives:
a. An assessment and treatment plan, according to R9-20-209; and
b. The treatment identified in the individual's treatment plan.

R9-20-504. ~~Supplemental Requirements for Outdoor Areas of Level I, II, and III Behavioral Health Facilities~~ Supplemental Requirements for Detoxification Services

~~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.~~

A. A licensee of an agency that provides detoxification services shall ensure that:
1. Policies and procedures are developed, implemented, and complied with for providing detoxification services and ensuring that a staff member providing detoxification services has skills and knowledge in providing detoxification services;
2. The agency's program description, completed according to R9-20-201(A)(2), includes:

a. Whether the agency provides involuntary, court-ordered alcohol treatment;
b. Whether the agency contains a local alcoholism reception center, as defined in A.R.S. § 36-2021; and
c. A description of:
i. The types of substances for which the agency provides detoxification services, and
ii. The detoxification process or processes used by the agency; and
3. Detoxification services are available at all times.

B. A licensee of an agency that provides detoxification services shall ensure that:
1. A psychiatrist or physician with skills and knowledge in providing detoxification services is present at the facility or on-call at all times;
2. A registered nurse is present at the facility at all times; and
3. A staff member who provides detoxification services has skills and knowledge in providing detoxification services that are verified according to R9-20-204(F)(2) and documented according to R9-20-204(G)(1) through (4).

C. A licensee of an agency that provides detoxification services shall ensure that a client in need of immediate medical services is admitted to the agency or transferred to an entity capable of meeting the client's immediate medical needs.

D. A licensee of an agency that provides detoxification services shall ensure that a client's treatment plan addresses the client's need for laboratory testing, such as drug screening.

R9-20-505. ~~Physical Plant Standards~~ Supplemental Requirements for a Level 1 RTC

~~**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.~~

A. A licensee of a Level 1 RTC shall ensure compliance with the following:
1. 42 CFR 441.150 and 441.152 through 441.156 (2000), incorporated by reference in R9-20-502(A)(3)(a);
2. 42 CFR 441.151, as published in 66 FR 7148 (2001) and amended in 66 FR 15800 (2001), incorporated by reference in R9-20-502(A)(3)(b);
3. 42 CFR 456.180, incorporated by reference in R9-20-502(A)(2)(b);
4. 42 CFR 456, Subpart J, incorporated by reference in R9-20-502(A)(2)(g);
5. 42 CFR Part 483, Subpart G, as published in 66 FR 7148 (2001) and amended in 66 FR 15800 (2001) and 66 FR 28110 (2001), incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available from U.S. Government Printing Office, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954;
6. R9-20-401;
7. R9-20-402;
8. R9-20-403;
9. R9-20-404(A)(1) through (A)(3), (A)(5) through (A)(9), and (B).
10. R9-20-405; and

11. R9-20-407.

B. A licensee of a Level 1 RTC shall ensure that:
1. A registered nurse is present at the facility full time to provide or oversee medical services; and
2. A nurse is present at the facility at all times.

C. A licensee of a Level 1 RTC shall ensure that within 24 hours after an individual's arrival at the agency, the individual is:
1. Admitted to the agency for treatment,
2. Transferred to another entity capable of meeting the individual's needs, or
3. Provided a referral to another entity capable of meeting the individual's needs.

D. A licensee of a Level 1 RTC shall ensure that a client who is a child does not:
1. Share a bedroom, indoor common area, dining area, outdoor area, or other area where behavioral health services or activities are provided with a client age 18 or older, unless the client age 18 or older is a client described under subsection (E)(2); or
2. Interact with a client who is age 18 or older, unless the client age 18 or older is a client described under subsection (E)(2).

E. A licensee of a Level 1 RTC may:
1. Admit an individual who is younger than 21; and
2. Continue to provide behavioral health services to a client age 18 or older until the client reaches the age of 22 if the client was admitted to the agency before the client's 21st birthday and continues to require treatment.

F. A licensee of a Level 1 RTC shall ensure that:
1. A fire inspection is conducted by the local fire department having jurisdiction or the Office of the State Fire Marshal according to the requirements of the local jurisdiction;
2. The most recent fire inspection report and documentation of any corrections stated in the inspection report are maintained on the premises or at the administrative office; and
3. The facility meets the fire safety requirements of the local jurisdiction and has:
    a. A fire alarm system, installed according to NFPA 72: National Fire Alarm Code (1999), incorporated by reference in R9-1-412(A)(4), with a fire alarm control panel that includes:
        i. A manual-pull fire alarm system,
        ii. Automatic occupancy notification,
        iii. A smoke or fire detection system, and
        iv. Notification of a local emergency response team; and
    b. An automatic sprinkler system that:
        i. Is installed as required in R9-20-406(C)(3)(b);
        ii. Has a water flow device; and
        iii. Has all control valve tampers tied into the fire alarm control panel.

R9-20-506. ~~Swimming Pools; In Ground or Permanently Installed~~ Supplemental Requirements for a Level 1 Sub-Acute Agency

~~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.~~
A. A licensee of a Level 1 sub-acute agency shall ensure compliance with the following:
1. If the agency is certified under Title XIX of the Social Security Act, R9-20-505(A)(1) through (5);
2. R9-20-401,
3. R9-20-402,
4. R9-20-403,
5. R9-20-404,
6. R9-20-405, and
7. R9-20-407.

B. A licensee of a Level 1 sub-acute agency shall ensure that a behavioral health technician is available at all times to admit an individual to the agency.
C. A licensee of a Level 1 sub-acute agency shall ensure that:
1. A written agreement is developed, implemented, and maintained at the facility or administrative office to provide the services of a psychiatrist as needed by the agency;
2. A behavioral health medical practitioner is present at the facility and available to see clients at least five days a week and sees and interacts with each client at least once a week;
3. A registered nurse is present at the facility full time to provide or oversee medical services;
4. A nurse is present at the facility at all times; and
5. There is a sufficient number of behavioral health professionals to meet the needs of the clients.

D. A licensee of a Level 1 sub-acute agency shall ensure that within 24 hours after a client's admission:
1. A client who is an adult receives a nursing assessment unless medical records are provided indicating that the client has received a physical examination or a nursing assessment within the 12 months before the date of the client's admission and the medical records are reviewed and verified as complete by a registered nurse or a medical practitioner;
2. A client who is a child receives a physical examination unless medical records are provided indicating that the client has received a physical examination within the 12 months before the date of the client's admission and the medical records are reviewed and verified as complete by a medical practitioner;
3. A client has an assessment performed by a registered nurse or medical practitioner according to the requirements in R9-20-209; and
4. A psychiatrist or behavioral health medical practitioner:
   a. Conducts the assessment or reviews the assessment and reviews other written information or records concerning the client, and
   b. Interacts with the client.

E. A licensee of a Level 1 sub-acute agency shall ensure that a progress note is written in a client record at least once every shift.
F. A licensee of a Level 1 sub-acute agency shall ensure that:
1. A fire inspection is conducted by the local fire department having jurisdiction or the Office of the State Fire Marshal according to the requirements of the local jurisdiction;
2. The most recent fire inspection report and documentation of any corrections stated in the inspection report are maintained on the premises or at the administrative office; and
3. The facility meets the fire safety requirements of the local jurisdiction and has:
   a. A fire alarm system, installed according to NFPA 72: National Fire Alarm Code (1999), incorporated by reference in R9-1-412(A)(4), with a fire alarm control panel that includes:
      i. A manual-pull fire alarm system,
      ii. Automatic occupancy notification,
      iii. A smoke or fire detection system, and
      iv. Notification of a local emergency response team; and
   b. An automatic sprinkler system that:
      i. Is installed as required in R9-20-406(C)(3)(b);
      ii. Has a water flow device; and
      iii. Has all control valve tampers tied into the fire alarm control panel.

ARTICLE 6. ~~LEVEL I BEHAVIORAL HEALTH SERVICE AGENCIES~~ USE OF RESTRAINT OR SECLUSION

R9-20-601. ~~Level I General Licensure Requirements~~ Definitions

~~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.~~

In addition to the definitions in R9-20-101, the following definitions apply in this Article unless otherwise specified:

1. "Emergency safety situation" means an unanticipated client behavior that:
   a. Places the client or another individual at imminent threat of violence or injury if no intervention occurs, and
   b. Calls for the use of restraint or seclusion.
2. "Minor" means:
   a. An individual under the age of 18 who is not an emancipated child, or
   b. A client who has been declared legally incompetent by a court of competent jurisdiction.
3. "Serious injury" means any significant impairment of the physical condition of the client as determined by a medical practitioner or nurse.
4. "Serious occurrence" means:
   a. A serious injury,
   b. A client's death, or
   c. A client's suicide attempt.

R9-20-602. ~~Level I Behavioral Health Facilities Providing Detoxification Services~~ Requirements for Use of Restraint or Seclusion

~~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.~~

A. A licensee shall ensure that:
1. A policy and procedure is developed, implemented, and complied with:
   a. For the use of each type of restraint or seclusion; and
   b. That identifies the qualifications of a staff member to:
      i. Order restraint or seclusion;
      ii. Place a client in restraint or seclusion;
      iii. Monitor a client in restraint or seclusion; and
      iv. Evaluate a client's physical and psychological well being within one hour after being placed in restraint or seclusion and upon being released from restraint or seclusion;
2. Restraint or seclusion is not used as a means of coercion, discipline, convenience, or retaliation;
3. An order for restraint or seclusion is not written as a PRN order;
4. Restraint or seclusion does not result in harm to a client and is only used:
   a. To ensure the safety of the client or another individual during an emergency safety situation;
   b. After other available less restrictive methods to control the client's behavior have been tried and were unsuccessful; and
   c. Until the emergency safety situation has ceased and the client's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired; and
5. Restraint and seclusion are not used on a client simultaneously, except in a Level 1 psychiatric hospital where restraint and seclusion may be used simultaneously if the client receives continuous:
   a. Face-to-face monitoring by a staff member; or
   b. Video and audio monitoring by a staff member who is in close proximity to the client.

B. A licensee shall ensure that restraint or seclusion is performed in a manner that is:
1. Safe; and
2. Proportionate and appropriate to the severity of a client's behavior and to the client's:
   a. Chronological and developmental age;
   b. Size;
   c. Gender;
   d. Physical condition;
   e. Medical condition;
   f. Psychiatric condition; and
   g. Personal history, including any history of physical or sexual abuse.

C. A licensee shall ensure that:
1. Restraint or seclusion is only ordered by:
   a. A physician providing treatment to the client; or
   b. If a physician providing treatment to the client is not present on the premises or on-call, a medical practitioner;
2. If the physician or medical practitioner who orders restraint or seclusion is not present, the physician's or medical practitioner's verbal order is obtained by a nurse at the time the restraint or seclusion is initiated;
3. A physician or medical practitioner who orders restraint or seclusion:
   a. Is available to staff members for consultation, at least by telephone, throughout the period of the restraint or seclusion; and

b. Orders the least restrictive restraint or seclusion that is likely to resolve the emergency safety situation, based upon consultation with staff members at the agency;
4. An order for restraint or seclusion includes:
   a. The name of the physician or medical practitioner ordering the restraint or seclusion;
   b. The date and time that the restraint or seclusion was ordered;
   c. The specific restraint or seclusion ordered;
   d. The specific criteria for release from restraint or seclusion without an additional order; and
   e. The maximum duration authorized for the restraint or seclusion;
5. An order for restraint or seclusion is limited to the duration of the emergency safety situation and does not exceed:
   a. Four hours for a client who is 18 years of age or older;
   b. Two hours for a client who is between the ages of nine and 17; or
   c. One hour for a client who is younger than nine;
6. A physician or medical practitioner ordering restraint or seclusion signs the order as soon as possible after the date of the order; and
7. If the medical practitioner ordering the use of restraint or seclusion is not a physician providing treatment to the client, the medical practitioner ordering restraint or seclusion:
   a. Consults with the physician providing treatment as soon as possible and informs that physician of the emergency safety situation that required the client to be restrained or placed in seclusion; and
   b. Provides documentation for the client record of the date and time that the physician providing treatment to the client was consulted.

D. A licensee shall ensure that a face-to-face assessment of a client's physical and psychological well-being is performed within one hour after the initiation of restraint or seclusion by a:
1. For a Level 1 psychiatric acute hospital, a medical practitioner, who is either on-site or on-call at the time that the restraint or seclusion was initiated; or
2. For a Level 1 RTC, a Level 1 sub-acute agency, or a Level 1 specialized transitional agency, registered nurse with at least one year of full time behavioral health work experience, who is either on-site or on-call at the time that the restraint or seclusion was initiated.

E. A licensee shall ensure that the face-to-face assessment, described in subsection (D) determines:
1. The client's physical and psychological status,
2. The client's behavior,
3. The appropriateness of the restraint or seclusion used,
4. Whether the emergency safety situation has passed; and
5. Any complication resulting from the restraint or seclusion used.

F. A licensee shall ensure that a staff member documents a client's restraint or seclusion in the client record:
1. Before the end of the shift in which restraint or seclusion occurs; or
2. If the restraint or seclusion does not end during the shift in which it began, during the shift in which restraint or seclusion ends.

G. A licensee shall ensure that a record is maintained at the agency of each emergency safety situation that includes:
1. Each use of restraint or seclusion;
2. Each order for restraint or seclusion, as required in subsection (C);
3. The times the restraint or seclusion actually began and ended;
4. The time and results of the face-to-face assessment required in subsection (D) through (E), (J)(2), and (K) as applicable;
5. Documentation of the monitoring required in subsection (H) and (I);
6. The emergency safety situation that required the client to be restrained or put in seclusion;
7. The names of the staff members involved in the restraint or seclusion; and
8. The outcome of each emergency safety situation or use of restraint or seclusion.

H. A licensee shall ensure that a client is monitored during a restraint as follows:
1. A staff member monitors the client's physical and psychological well-being and safety during the restraint on a face-to-face basis, except that a Level 1 psychiatric hospital may use video and audio monitoring according to subsection (A)(5)(b), as follows:
   a. At least once every 15 minutes;
   b. If the client has a medical condition that may be adversely impacted by the restraint or seclusion, at least once every five minutes; and
   c. If other clients have access to the client who is restrained or secluded, continuous staff monitoring on a one-to-one basis is provided;
2. If a client is in a restraint during a mealtime, the client is given the opportunity to eat and drink;
3. At least once every two hours, the client is given the opportunity to use a toilet; and
4. If a client is maintained in a mechanical restraint, the restraints are loosened at least once every 15 minutes.

I. A licensee shall ensure that:
1. A client is monitored during seclusion according to the requirements in subsection (H)(1);
2. A room used for seclusion:
   a. Is designated by the licensee as a room used for seclusion;
   b. Is not a client's bedroom or a sleeping area;
   c. Allows staff members full view of the client in all areas of the room;
   d. Is free of hazards, such as unprotected light fixtures or electrical outlets; and
   e. Contains at least 60 square feet of floor space;
3. If a client is in seclusion during a mealtime, the client is given the opportunity to eat and drink; and
4. At least once every two hours, a client in seclusion is given the opportunity to use a toilet.

J. A licensee shall ensure that if the emergency safety situation continues beyond the time limit of the order, the order for the use of restraint or seclusion may be renewed as follows:
1. An order for the use of restraint or seclusion may be renewed one time, according to the time-frames in subsection (C)(5);
2. If an emergency safety situation continues after the order is renewed one time, as described in subsection (J)(1), an individual who meets the qualifications in subsection (D) conducts a face-to-face assessment of the client's physical and psychological well-being before another order for restraint or seclusion is renewed; and
3. No order for restraint or seclusion is renewed for more than 12 consecutive hours without the review and approval of the medical director.

K. A licensee of a Level 1 RTC, a Level 1 sub-acute agency, or a Level 1 specialized transitional agency shall ensure that immediately after a client is removed from restraint or seclusion, a medical practitioner or registered nurse with at least one year of full time behavioral health work experience assesses the client's health, safety, and welfare.

L. A licensee shall ensure that:
1. If a client is a minor, the parent, guardian, or custodian of the client is notified, or an attempt is made to notify, as soon as possible and no later than one day after the initiation of restraint or seclusion or as requested by the parent, guardian, or custodian of the client; and
2. The notification required in subsection (L)(1) is documented in the client record and includes:
   a. The date and time of the notification or attempt, and
   b. The name of the staff member providing the notification.

M. A licensee shall ensure that within 24 hours after the use of restraint or seclusion face-to-face debriefings occur or are scheduled to occur within seven days as follows:
1. Both the client, unless the client declines to participate, and all staff members involved in the restraint or seclusion receive a debriefing, although the client and staff member debriefings do not need to occur at the same time;
2. A client's debriefing is conducted:
   a. By a behavioral health professional; and
   b. In a language that is understood by the client and, if present, the client's parent, guardian, or custodian;
3. A debriefing may include the client's parent, guardian, or custodian and other staff members, if directed by the clinical director or the clinical director's designee;
4. A debriefing provides the client and staff members the opportunity to discuss the circumstances that resulted in restraint or seclusion and strategies that could be used by the client, staff members, or other individuals to prevent future use of restraint or seclusion; and
5. Each debriefing is documented at the agency and includes the:
   a. The date of the debriefing;
   b. The names of the individuals participating in the debriefing;
   c. The precipitating factors that led up to the restraint or seclusion;
   d. Alternative techniques that were used to prevent the use of restraint or seclusion;
   e. The outcome of the restraint or seclusion, including any injuries that may have resulted from the restraint or seclusion; and
   f. If any individual was injured, the circumstances that caused the injury and a plan to prevent future injuries.

N. A licensee shall ensure that, at least once a month, the clinical director or medical director reviews documentation of each use of restraint or seclusion that has occurred at the agency in the past month as follows:
1. The clinical director or medical director determines and documents:
   a. Whether staff members are using restraint or seclusion according to the agency's policy and procedure, this Chapter, and applicable federal or state laws and rules;
   b. Actions to be taken by the agency to prevent the use of restraint or seclusion, such as additional staff training or changes to agency policy and procedure;
   c. Whether a client is appropriately placed at the agency; and
   d. Whether the client's treatment plan should be reviewed or revised to ensure that the client's treatment is meeting the client's treatment needs; and

2. Provides the documentation required in subsection (N)(1) to the OBHL within five days after the end of the calendar month and documentation is maintained at the agency that the written report was provided.

O. A licensee shall ensure that:
1. If restraint or seclusion results in injury to a client, staff members immediately obtain medical treatment for the client;
2. The licensee is affiliated with or develops and implements a written transfer agreement with one or more hospitals that provide acute medical services or psychiatric acute services and ensures that:
   a. A client who is injured is transferred to a hospital in time to meet the client's medical or psychiatric needs;
   b. A client's medical record or other information needed for the client's treatment is exchanged between the hospital and the licensee according to the requirements in R9-20-211(A)(3) and (B); and
   c. Medical services or psychiatric services provided by a hospital are available to a client at all times; and
3. All injuries that occur as a result of a client's restraint or seclusion, including injuries to staff members, are documented in the client record.

P. A licensee shall ensure that:
1. If a client involved in a serious occurrence is a minor, the client's parent, guardian, or custodian is notified as soon as possible and no later than 24 hours after the serious occurrence; and
2. Compliance is maintained with the applicable requirements in R9-20-202(A) and (B).

Q. A licensee shall ensure that any staff member, including a medical practitioner, who is involved in ordering restraint or seclusion, performing restraint or seclusion, monitoring a client during restraint or seclusion, or evaluating a client after restraint or seclusion:
1. Before participating in restraint or seclusion, completes education and training:
   a. That includes:
      i. Techniques to identify staff member and client behaviors, events, and environmental factors that may trigger emergency safety situations;
      ii. The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods;
      iii. The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in a client who is restrained or secluded; and
      iv. Training exercises in which staff members successfully demonstrate in practice the techniques that they have learned for managing emergency safety situations; and
   b. Taught by individuals who have education, training, and experience in preventing and using restraint or seclusion;
2. For a Level 1 RTC and a Level 1 sub-acute agency, demonstrates skills and knowledge in the subject areas in subsection (Q)(1)(a) at least once every six months, that are verified according to R9-20-204(F)(2) and documented according to R9-20-204(G)(1) through (4);
3. Successfully completes CPR training that includes a demonstration of the staff member's ability to perform CPR at least once every 12 months; and
4. Has documentation in the staff member's personnel file indicating compliance with the training requirements of subsections (Q)(1) through (3) and including:
   a. The date training was completed; and
   b. The name of the individual verifying the staff member's completion of the training.

R. A licensee shall ensure that all training materials related to restraint or seclusion used by the licensee are available for review at the agency.

S. If a client is enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, a licensee shall ensure that, in addition to meeting the requirements in this Section, the licensee meets the requirements for restraint or seclusion in 9 A.A.C. 21.

R9-20-603. ~~Level I Behavioral Health Facilities Providing Restrictive Behavior Management~~ Repealed

~~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.~~

R9-20-604. ~~Level I Behavioral Health Facilities Providing Psychiatric Acute Care~~ Repealed

~~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.~~

R9-20-605. ~~Level I Behavioral Health Facilities Providing Intensive Services~~ Repealed

~~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.~~

ARTICLE 7. ~~LEVEL II BEHAVIORAL HEALTH SERVICE AGENCIES~~ LEVEL 1 SPECIALIZED TRANSITIONAL AGENCY

R9-20-701. ~~**Level II General Licensure Requirements**~~ **Supplemental Requirements for a Level 1 Specialized Transitional Agency**

~~**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.~~

A. A licensee of a Level 1 specialized transitional agency shall ensure compliance with:
1. A.R.S. Title 36, Chapter 37;
2. R9-20-402;
3. R9-20-403; and
4. R9-20-407.

B. A licensee of a Level 1 specialized transitional agency shall ensure that policies and procedures are developed, implemented, and complied with that include:
1. A description of the clothing that a client is required and permitted to wear;
2. The process for the issuance and return of a razor or other potentially hazardous object;
3. Requirements regarding locking a client in the client's bedroom, including:
   a. The training required for a staff member who locks a client in the client's bedroom;
   b. The criteria for locking a client in the client's bedroom;
   c. A requirement that the need for a client to be locked in the client's bedroom be evaluated and adjusted, if necessary, by a psychiatrist or psychologist each time the client's treatment plan is reviewed as required by subsection (D)(3);
   d. The procedures that may be used to lock a client in the client's bedroom;
   e. The monitoring that is required while a client is locked in the client's bedroom; and
   f. The criteria for releasing a client from the client's bedroom;
4. The process and criteria for determining whether a client is capable of and eligible to self administer medication;
5. A client's visitation privileges; and
6. The criteria for using a locking mechanism to restrict a client's movement during transport.

C. A licensee of a Level 1 specialized transitional agency shall ensure that, in addition to the staffing requirements contained in R9-20-207, staffing is provided as follows:
1. A medical practitioner is present at the facility at least ten hours a week;
2. A psychiatrist is present at the facility at least ten hours a week;
3. A registered nurse is present at the facility at all times;
4. Each of the following staff members is present at the facility full time:
   a. A psychologist;
   b. A social worker;
   c. A registered nurse with overall responsibility for the provision of nursing services; and
   d. An individual who provides educational activities and social, recreational, or rehabilitative activities;
5. Between 7:00 a.m. and 11:00 p.m., at least one behavioral health paraprofessional is present at the facility for every 15 clients;
6. Between 11:00 p.m. and 7:00 a.m., at least one behavioral health paraprofessional is present at the facility for every 30 clients;
7. At least two employees responsible for maintaining a safe and secure facility are located outside the facility at all times; and
8. At least one employee for every 30 clients is responsible for maintaining a safe and secure facility and is located inside the facility at all times.

D. A licensee of a Level 1 specialized transitional agency shall ensure that:
1. Within seven days after the date that an individual is committed to the custody of the Department for treatment:
   a. The client receives a physical examination,
   b. Medical records are provided indicating that the client received a physical examination within 12 months before the date of the client's admission and are reviewed and verified as current and complete by a medical practitioner, or
   c. The client's refusal of a physical examination is documented in the client record;
2. A client's assessment and treatment plan is initiated within 30 days after the date the client is admitted for treatment and is completed within 90 days after that date;
3. A client's treatment is reviewed, and the client's treatment plan is updated according to the requirements in R9-20-209(I)(7) and at least once every 30 days; and
4. Progress notes are written in a client record at least:

a. Once every shift for the first seven days after the date of the client's admission for treatment, and
b. Once each day thereafter.

E. A licensee of a Level 1 specialized transitional agency shall ensure that:
1. A client receives treatment in a secure facility;
2. A client's rights are denied only if necessary to protect the safety of the client or others as determined according to A.R.S. § 36-507(E); and
3. Transportation of a client is provided according to the agency's policy and procedure and R9-20-212 and as follows:
   a. Sufficient staff members are present during transportation to meet the health, safety, and security needs of the client, other individuals, and the community; and
   b. A locking mechanism may be used to restrict a client's physical movement during transportation to another portion of the facility, another facility, or another entity to ensure the health and safety of the client, other individuals, and the community.

F. A licensee of a Level 1 specialized transitional agency shall ensure that a premises has:
1. An indoor common area that is not used as a sleeping area and that has:
   a. A working telephone that allows a client to make a private telephone call;
   b. A distortion-free mirror;
   c. A current calendar and an accurate clock;
   d. A variety of books, current magazines and newspapers, and arts and crafts supplies appropriate to the age, educational, cultural, and recreational needs of clients;
   e. A working television and access to a radio; and
   f. Space sufficient to accommodate the social and recreational needs of clients;
2. A dining room or dining area that:
   a. Is lighted and ventilated,
   b. Contains tables and seats, and
   c. Is not used as a sleeping area;
3. An outdoor area that:
   a. Is accessible to clients,
   b. Has sufficient space to accommodate the social and recreational needs of clients, and
   c. Has shaded and unshaded areas; and
4. Bathrooms that contain at least:
   a. One working bathtub or shower, with a slip resistant surface, for every 12 clients; and
   b. One working flushable toilet, with a seat, for every ten clients.

G. A licensee of a Level 1 specialized transitional agency shall ensure that a client's sleeping area is in a bedroom that:
1. Is a private bedroom that contains at least 60 square feet of floor space, not including the closet;
2. Contains a door that opens into a corridor, common area, or the outside;
3. Is constructed and furnished to provide unimpeded access to the door;
4. Is not used as a passageway to another bedroom or a bathroom unless the bathroom is for the exclusive use of the individual occupying the bedroom; and
5. Contains the following for each client:
   a. An individual storage space, such as a dresser or chest;
   b. A bed that:
      i. Consists of at least a mattress and frame;
      ii. Is in good repair, clean, and free of odors and stains; and
      iii. Is at least 36 inches wide and 72 inches long; and
   c. A pillow and linens that are clean, free of odors, and in good repair, including:
      i. A mattress pad;
      ii. A top sheet and a bottom sheet that are large enough to tuck under the mattress;
      iii. A pillow case;
      iv. A waterproof mattress cover, if needed; and
      v. A blanket or bedspread sufficient to ensure the client's warmth.

H. A licensee of a Level 1 specialized transitional agency shall ensure that:
1. The supply of hot water is sufficient to meet:
   a. Each client's daily personal hygiene needs; and
   b. The laundry, cleaning, and sanitation requirements in this Chapter;
2. Clean linens and bath towels are provided to a client as needed and at least once every seven days;
3. One of the following is available to ensure that client clothing can be cleaned:
   a. A working washing machine and dryer on the premises,
   b. An agency-provided process for cleaning clothing, or

c. An agency-provided process for transporting a client to a building with washing machines and dryers that a client can use;
4. Soiled linen and clothing stored by the licensee are in covered containers or closed plastic bags away from a food preparation or storage area or a dining area; and
5. Pets and animals, except for service animals, are prohibited on the premises.

I. A licensee of a Level 1 specialized transitional agency shall ensure that:
1. A facility meets the fire safety requirements of the local jurisdiction,
2. A fire inspection is conducted by the local fire department having jurisdiction or the Office of the State Fire Marshal according to the requirements of the local jurisdiction, and
3. The most recent fire inspection report and documentation of any corrections stated on the inspection report are maintained on the premises or at the administrative office.

R9-20-702. ~~Level II Behavioral Health Facility Providing Structured Services~~ Repealed

~~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.~~

ARTICLE 8. ~~LEVEL III BEHAVIORAL HEALTH SERVICE AGENCIES~~ COURT-ORDERED SERVICES

R9-20-801. ~~Level III General Licensure Requirements~~ Supplemental Requirements for Pre-petition Screening Services

~~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.~~

A. A licensee of an agency that only provides pre-petition screening is not required to comply with the following provisions in this Chapter:
   1. R9-20-208 and other requirements related to admission,
   2. R9-20-209 and other requirements related to a client's assessment or treatment plan, and
   3. R9-20-210 and other requirements related to a client's discharge.

B. A licensee of an agency that provides pre-petition screening shall ensure compliance with the pre-petition screening requirements in A.R.S. Title 36, Chapter 5.

C. A licensee of an agency that provides pre-petition screening shall ensure that:
   1. Policies and procedures are developed, implemented, and complied with for conducting a pre-petition screening;
   2. Assistance is provided to an individual filing an application for a court-ordered evaluation, according to A.R.S. § 36-520(D);
   3. If an application for a court-ordered evaluation is not acted upon because it has been determined that the proposed client does not need an evaluation, the application for a court-ordered evaluation and any evidence of the application for a court-ordered evaluation are destroyed according to A.R.S. § 36-520(I);
   4. A pre-petition screening is conducted according to the definition in A.R.S. § 36-501 and according to A.R.S. §§ 36-520(E) and (F) and 36-521(A);
   5. After a pre-petition screening is conducted, a written report is prepared and reviewed according to A.R.S. § 36-521(B) and (C);
   6. A petition for a court-ordered evaluation:
      a. Is prepared according to A.R.S. § 36-521(D), and
      b. Contains the information required according to A.R.S. § 36-523 (A) through (C);
   7. Before a petition for court-ordered evaluation that alleges danger to others is filed, the county attorney is contacted to review the petition according to A.R.S. § 36-521(G);
   8. An evaluation agency is notified of an individual requiring a voluntary evaluation, according to A.R.S. § 36-522(A);
   9. A petition for a court-ordered evaluation that is not filed and all reports annexed to the petition are destroyed according to A.R.S. § 36-523(E); and
   10. An application for emergency admission meets the requirements in A.R.S. § 36-524.

R9-20-802. ~~Level III Behavioral Health Facilities Providing Supervised Services~~ Supplemental Requirements for Court-Ordered Evaluation

~~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.~~

A. A licensee of an agency that only provides court-ordered evaluation is not required to comply with the following provisions in this Chapter:
1. R9-20-208 and other requirements related to admission,
2. R9-20-209 and other requirements related to a client's assessment or treatment plan,
3. R9-20-210 and other requirements related to a client's discharge.

B. A licensee of an agency that provides court-ordered evaluation shall ensure compliance with the court-ordered evaluation requirements in A.R.S. Title 36, Chapter 5.

C. A licensee of an agency that provides court-ordered evaluation shall ensure that:
1. Policies and procedures are developed, implemented, and complied with for conducting a court-ordered evaluation;
2. A medical director is appointed who:
   a. Meets the definition of a medical director of an evaluation agency in A.R.S. § 36-501, and
   b. May deputize an individual according to A.R.S. § 36-503;
3. If a client is receiving an evaluation according to A.R.S. §§ 36-520 through 36-531, persons are notified according to A.R.S. § 36-504(B);
4. A staff member or employee does not deprive a client of a client right identified in A.R.S. §§ 36-504(A), 36-506 (A) or (B), 36-507, 36-512, 36-514, 36-520 (H), or 36-528(D);
5. If a petition for a court-ordered evaluation is not filed because the individual for whom the evaluation is sought requests a voluntary evaluation, a voluntary evaluation is not conducted unless:
   a. For a voluntary inpatient evaluation, informed consent is obtained according to A.R.S. § 36-518; and
   b. For a voluntary outpatient evaluation, informed consent is obtained according to A.R.S. § 36-522(C);
6. A client admitted to an agency for an evaluation under an emergency admission does not receive treatment unless consent is obtained according to A.R.S. § 36-528(A), except as otherwise provided according to A.R.S. § 36-528(A);
7. A client's records and information are confidential and are not disclosed except according to A.R.S. §§ 12-2292, 36-504, 36-509, and 36-517.01;
8. An evaluation is conducted according to the definition in A.R.S. § 36-501 and according to A.R.S. §§ 36-511(A), 36-513, and 36-530;
9. If a client is evaluated on an inpatient basis and does not make application for further care and treatment:
   a. The client is discharged according to A.R.S. §§ 36-506(D), 36-531(A) and (D), and 36-534; or
   b. A petition for court-ordered treatment is prepared and filed according to A.R.S. §§ 36-531(B) and (C) and 36-533;
10. Before a hearing on a petition for court-ordered treatment, information is provided to:
    a. The client's attorney, according to A.R.S. § 36-537(A); and

b. The physicians treating the client, according to A.R.S. § 36-539(A);
11. At the hearing on a petition for court-ordered treatment, testimony is provided by the physicians who conducted the evaluation, according to A.R.S. § 36-539(B);
12. If a petition for court-ordered evaluation is not filed because it has been determined that the proposed client will voluntarily receive an evaluation and is unlikely to present a danger to self or others pending the voluntary evaluation, a voluntary evaluation is conducted according to the requirements in A.R.S. §§ 36-518 and 36-522;
13. If a client admitted voluntarily according to A.R.S. § 36-522 is discharged, the discharge meets the requirements in A.R.S. § 36-519; and
14. A client receives an emergency evaluation according to:
    a. The admission requirements in A.R.S. §§ 36-524, 36-526, and 36-527(A);
    b. The consent requirements in A.R.S. § 36-528(A);
    c. The notification requirements in A.R.S. § 36-528(B) and (D);
    d. The requirements for protection of personal property in A.R.S. § 36-528(C); and
    e. The discharge requirements in A.R.S. § 36-527(B).

R9-20-803. Supplemental Requirements for Court-Ordered Treatment

A. A licensee of an agency that provides court-ordered treatment shall ensure compliance with the court-ordered treatment requirements in A.R.S. Title 36, Chapter 5, Article 5.

B. A licensee of an agency that provides court-ordered treatment shall ensure that:
1. Policies and procedures are developed, implemented, and complied with for providing court-ordered treatment;
2. A medical director is appointed who:
    a. Meets the definition of a medical director of a mental health treatment agency in A.R.S. § 36-501, and
    b. May deputize an individual according to A.R.S. § 36-503;
3. If a client is receiving court-ordered treatment according to A.R.S. §§ 36-533 through 36-544, the following persons are immediately notified according to A.R.S. § 36-504(B):
    a. The client's guardian or, if the client does not have a guardian, a family member of the client; and
    b. The client's agent, if applicable;
4. A staff member or employee does not deprive a client of a client right identified in A.R.S. §§ 36-504(A), 36-506(A) or (B), 36-507, 36-510, 36-512, 36-514, or 36-520(H);
5. The property of a client receiving court-ordered treatment is protected according to A.R.S. § 36-508;
6. Client records and information are confidential and are not disclosed except according to A.R.S. §§ 12-2292, 36-504, and 36-517.01;
7. Treatment:
    a. Is provided according to the requirements in A.R.S. §§ 36-511, 36-540(E) and (K), and 36-540.01;
    b. Is documented according to the requirements in A.R.S. § 36-511(A); and
    c. Is provided without the use of restraint or seclusion, except as provided in A.R.S. § 36-513;
8. A client who has been found to be gravely disabled and who is undergoing court-ordered treatment receives an annual examination and review to determine whether the continuation of court-ordered treatment is appropriate according to A.R.S. § 36-543(D) through (F);
9. A client is discharged according to A.R.S. §§ 36-506(D), 36-519, 36-541.01, 36-542, and 36-543(A) and (B); and
10. If a client seeks judicial review, the medical director complies with the requirements in A.R.S. § 36-546.

ARTICLE 9. ~~EMERGENCY/CRISIS BEHAVIORAL HEALTH SERVICES~~ DUI

R9-20-901. ~~General Licensure Requirements for Emergency/Crisis Behavioral Health Services~~ Exceptions for a Licensee of an Agency That Only Provides DUI Screening or DUI Education or Both

~~**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.~~

A licensee of an agency that only provides DUI screening or DUI education or both is not required to comply with the following:
1. R9-20-208,
2. R9-20-209, and
3. R9-20-210.

R9-20-902. ~~Emergency/Crisis Behavioral Health Services~~ Supplemental Requirements for DUI Screening

~~**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 emergency 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.~~

<u>**A.** A licensee of an agency that provides DUI screening shall ensure that policies and procedures are developed, implemented, and complied with for:</u>
<u>1. Conducting DUI screening,</u>
<u>2. Tracking and referring a DUI client to DUI education or DUI treatment, and</u>
<u>3. Communicating with and reporting information to a referring court.</u>

<u>**B.** A licensee of an agency that provides DUI screening shall ensure that:</u>
<u>1. The following information is reported to the referring court:</u>
<u>a. The results of a DUI client's DUI screening;</u>
<u>b. The agency's recommendations, based upon the DUI screening, for DUI education or DUI treatment;</u>
<u>c. The name of the licensed agency selected by the client to provide DUI education or DUI treatment; and</u>
<u>d. If the DUI client is enrolled in DUI education or DUI treatment, the DUI client's compliance, progress, and completion; and</u>
<u>2. The referring court receives written notification within five working days, unless otherwise specified by the court, when a DUI client:</u>
<u>a. Fails to obtain or complete DUI screening;</u>
<u>b. Fails to pay the cost of DUI screening;</u>
<u>c. Fails to comply with or to complete DUI education or DUI treatment; or</u>
<u>d. Completes DUI screening, DUI education, or DUI treatment.</u>

<u>**C.** A licensee of an agency that provides DUI screening shall ensure that a client's DUI screening:</u>
<u>1. Occurs within 30 days after the date of the court order, unless otherwise required in the court order;</u>
<u>2. Is conducted by a behavioral health professional or a behavioral health technician;</u>
<u>3. Consists of a face-to-face interview that lasts at least 30 minutes but not more than three hours;</u>
<u>4. Includes administering at least one standardized instrument for measuring alcohol dependency or substance abuse, such as the Driver Risk Inventory, the Michigan Alcoholism Screening Test, the Minnesota Multiphasic Personality Inventory, the Mortimer-Filkins, or the Substance Abuse Subtle Screening Inventory; and</u>
<u>5. Is documented in the client record.</u>

<u>**D.** A licensee of an agency that provides DUI screening shall ensure that a DUI client is given the following information in writing before DUI screening is conducted and that the DUI client's receipt of the information is documented:</u>
<u>1. The procedures for conducting DUI screening;</u>
<u>2. The timeline for initiating and completing DUI screening;</u>
<u>3. The consequences to the DUI client for not complying with the procedures and timeline; and</u>
<u>4. The cost and methods of payment for DUI screening, DUI education, and DUI treatment.</u>

E. A licensee of an agency that provides DUI screening shall classify a DUI client based upon the information obtained in the DUI screening as follows:
1. A Level 1 DUI client:
   a. Meets at least one of the following:
      i. Has previously been arrested or convicted two or more times for alcohol or drug-related offenses;
      ii. Had an alcohol concentration of 15 or higher at the time of the arrest that led to the current referral;
      iii. Has been unable to control use of alcohol or drugs or has habitually abused alcohol or drugs;
      iv. Admits a problem controlling alcohol or drug use;
      v. Has been diagnosed with substance abuse or organic brain disease resulting from substance abuse;
      vi. Has experienced symptoms of withdrawal from alcohol or drug use that included visual, auditory, or tactile hallucinations; convulsive seizures; or delirium tremens; or
      vii. Has been diagnosed with alcoholic liver disease, alcoholic pancreatitis, or alcoholic cardiomyopathy by a medical practitioner; or
   b. Meets at least three of the following, based upon the results of a standardized instrument described in subsection (C)(4):
      i. Provided responses during DUI screening that indicated substance abuse;
      ii. Had an alcohol concentration of .08 or higher at the time of the arrest that led to the current referral;
      iii. Has previously been arrested or convicted one time for an alcohol-or drug-related offense;
      iv. Has experienced a decrease in attendance or productivity at work or school as a result of drug or alcohol use;
      v. Has experienced family, peer, or social problems associated with drug or alcohol use;
      vi. Has previously participated in substance abuse education or treatment for problems associated with alcohol or drug use;
      vii. Has experienced blackouts as a result of alcohol or drug use;
      viii. Has passed out as a result of drug or alcohol use;
      ix. Has experienced symptoms of withdrawal from alcohol or drug use including shakes or malaise relieved by resumed alcohol or drug use; irritability; nausea; or anxiety;
      x. Exhibits a psychological dependence on drugs or alcohol;
      xi. Has experienced an increase in consumption or tolerance or a change in the pattern of alcohol or drug use; or
      xii. Has experienced personality changes associated with alcohol or drug use; and
2. A Level 2 DUI client:
   a. Does not meet any of the criteria in subsection (E)(1)(a); and
   b. Meets two, one, or none of the criteria in subsection (E)(1)(b).

F. A licensee of an agency that provides DUI screening shall ensure that after completing a client's DUI screening:
1. The results of the DUI screening are documented in the client record and include:
   a. The DUI client's alcohol concentration at the time of the arrest that led to the current referral, if available;
   b. The DUI client's history of alcohol and drug use;
   c. The DUI client's history of treatment associated with alcohol or drug use; and
   d. The DUI client's history of impairments in physical, educational, occupational, or social functioning as a result of alcohol or drug use; and
2. A recommendation is made to the referring court for DUI education or DUI treatment or both, and referrals are made as follows:
   a. A Level 1 DUI client is referred to:
      i. An agency that provides DUI education for at least 16 hours of DUI education; and
      ii. An agency that provides DUI treatment for at least 20 hours of DUI treatment; and
   b. A Level 2 DUI client is referred to an agency that provides DUI education for at least 16 hours of DUI education.

G. A licensee of an agency that provides DUI screening may refer a Level 1 or Level 2 DUI client to a self-help or peer-support program that assists individuals in achieving and maintaining freedom from alcohol or drugs, such as Alcoholics Anonymous or Narcotics Anonymous. Participation in a self-help group or peer support program is not DUI education or DUI treatment and does not count toward required hours in DUI education or DUI treatment.

H. A licensee of an agency that provides DUI screening shall ensure that a referral of a DUI client made under subsection (F)(2) includes:
1. Providing the DUI client with the following information about three agencies authorized to provide DUI education or DUI treatment, as applicable, in the geographic area requested by the DUI client, at least two of which are not owned by, operated by, or affiliated with the licensee of the DUI screening agency:
   a. Name,
   b. Address, and

c. Telephone number;
2. Instructing the DUI client:
   a. To select an agency that provides DUI education or DUI treatment, as applicable;
   b. To schedule an appointment or enroll in DUI education or DUI treatment, as applicable, within five working days after the date of completion of the DUI screening; and
   c. To notify the DUI screening agency of the name of the agency selected to provide DUI education or DUI treatment, as applicable;
3. Obtaining, in writing, a DUI client's permission to release information to the selected agency; and
4. Providing the following in writing to the selected agency and the referring court within five working days after the DUI client's completion of DUI screening:
   a. The date that the DUI client completed DUI screening;
   b. The results of DUI screening;
   c. The recommendations of the DUI screening agency made under subsection (F)(2); and
   d. The name of the DUI education or DUI treatment agency selected by the client.

I. A licensee of an agency that provides DUI screening shall maintain a record for each DUI client that contains:
1. The citation number or complaint number from the arrest that led to the current referral, if available;
2. A copy of the documents referring the DUI client to DUI screening, if available;
3. Documentation of the DUI client's receipt of the information contained in subsection (D);
4. Documentation of the client's DUI screening, including the completed standardized instrument required under subsection (C)(4);
5. Documentation of the recommendations and referrals for DUI education or DUI treatment, as applicable, required under subsections (F)(2) and (H);
6. The DUI client's signed and dated release of information required under subsection (H)(3); and
7. A copy of the information provided to the agency selected to provide DUI education or DUI treatment, as applicable, and to the referring court as required under subsection (H)(4).

R9-20-903. ~~Mobile Crisis Services~~ Supplemental Requirements for DUI Education

~~**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.~~

A. A licensee of an agency that provides DUI education shall ensure that a DUI client is given the following information in writing before DUI education is conducted and that the DUI client's receipt of the information is documented:
1. The procedures for conducting DUI education;
2. The timeline for initiating and completing DUI education;
3. The consequences to the DUI client for not complying with the procedures and timeline;
4. he information that will be contained in a report to the DUI screening agency or the referring court; and
5. The cost and methods of payment for DUI education and DUI treatment.

B. A licensee of an agency that provides DUI education shall ensure that:
1. DUI education is provided in a classroom setting;
2. A current written schedule of DUI education classes is maintained at the agency;
3. DUI education consists of at least 16 hours in the classroom setting;
4. DUI education is scheduled to be completed within eight weeks from the date of the first class;
5. The number of DUI clients enrolled in a class of DUI education does not exceed 30; and
6. DUI education is provided by a behavioral health professional or behavioral health technician.

C. Participation in a self-help group or peer support program, such as Alcoholics Anonymous or Narcotics Anonymous, is not DUI education and does not count toward required hours in DUI education.

D. A licensee of an agency that provides DUI education shall ensure that:

1. A written pre-test is administered to a DUI client before receiving DUI education to measure the DUI client's knowledge of the subject areas listed in subsection (D)(2);
2. DUI education includes information on:
   a. The physiological effects of alcohol and drug use;
   b. How alcohol use and drug use affect an individual's ability to operate a vehicle, including how an individual's alcohol concentration is measured and how alcohol concentration impacts an individual's ability to operate a vehicle;
   c. Alternatives to operating a motor vehicle while impaired by alcohol or drug use;
   d. The psychological and sociological effects of alcohol and drug use;
   e. The stages of substance abuse;
   f. Self-assessment of alcohol or drug use;
   g. Criminal penalties and statutory requirements for sentencing DUI clients;
   h. Alternatives to alcohol or drug use;
   i. Identification of different approaches to the treatment of substance abuse;
   j. Resources, programs, and interventions available in the community for treatment of substance abuse; and
   k. Orientation to the process and benefits of group counseling and self-help groups such as Alcoholics Anonymous and Narcotics Anonymous; and
3. A written post-test is administered to a DUI client after receiving DUI education to measure the DUI client's knowledge of the subject areas listed in subsection (D)(2).

E. A licensee of an agency that provides DUI education shall ensure that a policy and procedure is developed, implemented, and complied with for using the results of pre-tests and post-tests required under subsection (D) for analyzing the licensee's DUI education program.

F. A licensee of an agency that provides DUI education shall ensure that a DUI client who completes DUI education receives written documentation that indicates satisfactory completion of DUI education and includes:
1. The name of the agency providing the DUI education,
2. The date of completion, and
3. The name of the DUI client.

G. A licensee of an agency that provides DUI education shall ensure that a policy and procedure is developed, implemented, and complied with for providing written notification of the following events to the DUI screening agency and, if applicable, the referring court within five working days after the event:
1. A DUI client's failure to enroll in DUI education by the deadline established by the DUI screening agency or the referring court;
2. A DUI client's failure to comply with the requirements of DUI education, including failure to attend DUI education or failure to pay required costs; and
3. A DUI client's completion of DUI education.

H. A licensee of an agency that provides DUI education shall ensure that, for each DUI client, a written report is prepared and provided to the DUI screening agency and, if applicable, the referring court that includes:
1. Whether the DUI client:
   a. Enrolled in DUI education and the date of enrollment;
   b. Complied with the requirements of DUI education; and
   c. Completed DUI education and, if so, the date of completion; and
2. Any recommendation for additional DUI education or for DUI treatment.

I. A licensee of an agency that provides DUI education may refer a DUI client back to the DUI screening agency:
1. If the DUI education agency determines that a DUI client's treatment needs cannot be met by the DUI education agency because the DUI client:
   a. Requires behavioral health services that the DUI education agency is not authorized or able to provide,
   b. Has a physical or other disability that the DUI education agency is unable to accommodate, or
   c. Requires education to be provided in a language in which instruction is not provided by the DUI education agency; and
2. With written documentation of the reason that the DUI education agency is unable to meet the DUI client's treatment needs and a recommendation for additional or alternative DUI education that would meet the DUI client's treatment needs.

J. A licensee of an agency that provides DUI education shall maintain a record for each DUI client that contains:
1. Documents received from the DUI screening agency or referring court regarding the DUI client;
2. Documentation that the DUI client received the information contained in subsection (A);
3. The pre-test and post-test completed by the DUI client;
4. The dates of the DUI client's attendance at DUI education;
5. A copy of the documentation indicating the DUI client's satisfactory completion of DUI education as described under subsection (F);

6. A copy of the report provided to the DUI screening agency or referring court as required in subsection (H);
7. A copy of the written documentation provided to the DUI screening agency or court as described in subsection (I); and
8. Documentation of any written information or verbal contact regarding the DUI client with the DUI screening agency; the referring court, if any; a Department of Motor Vehicles; or another agency authorized to provide DUI education or DUI treatment.

R9-20-904. Supplemental Requirements for DUI Treatment

A. A licensee of an agency that provides DUI treatment shall ensure that a policy and procedure is developed, implemented, and complied with for providing written notification of the following events to the DUI screening agency and, if applicable, the referring court within five working days after the event:
1. A DUI client's failure to enroll in DUI treatment by the deadline established by the DUI screening agency or the referring court;
2. A DUI client's failure to comply with the requirements of DUI treatment, including failure to attend DUI treatment or failure to pay required costs; and
3. A DUI client's completion of DUI treatment

B. A licensee of an agency that provides DUI treatment shall ensure that a DUI client is given the following information in writing before DUI treatment is conducted and that the DUI client's receipt of the information is documented:
1. The procedures for conducting DUI treatment,
2. The timeline for initiating and completing DUI treatment,
3. The consequences to the DUI client for not complying with the procedures and timeline,
4. The information that will be contained in a report to the DUI screening agency or the referring court, and
5. The cost and methods of payment for DUI treatment.

C. A licensee of an agency that provides DUI treatment shall ensure that DUI treatment:
1. Is based upon the information and results obtained from the DUI screening agency or referring court; and
2. Includes at least 20 hours of group counseling that:
   a. Is provided by a behavioral health technician or behavioral health professional;
   b. Is provided in at least ten sessions that last between 90 and 120 minutes each;
   c. Includes no more than 15 DUI clients or, if family members participate in group counseling, 20 individuals; and
   d. Is documented in a client record.

D. Participation in a self-help group or peer support program, such as Alcoholics Anonymous or Narcotics Anonymous, is not DUI treatment and does not count toward required hours in DUI treatment.

E. A licensee of an agency that provides DUI treatment shall ensure that, for each DUI client, a written report is prepared and provided to the DUI screening agency and, if applicable, the referring court according to the timeline established by the DUI screening agency and the DUI treatment agency that includes:
1. Whether the DUI client:
   a. Enrolled in DUI treatment and the date of enrollment;
   b. Complied with the requirements of DUI treatment; and
   c. Completed DUI treatment and, if so, the date of completion;
2. The DUI client's progress in DUI treatment; and
3. Any recommendation for additional DUI treatment.

F. A licensee of an agency that provides DUI treatment shall ensure that:
1. DUI treatment is scheduled to be completed within 16 weeks after the date that the client was admitted into DUI treatment; and
2. A DUI client, after completing DUI treatment, receives an exit interview from a staff member that includes a review of the information contained in the report required in subsection (E).

G. A licensee of an agency that provides DUI treatment may refer a DUI client back to the DUI screening agency:
1. If the DUI treatment agency determines that the DUI client's treatment needs cannot be met by the DUI treatment agency because the DUI client:
   a. Requires behavioral health services that the DUI treatment agency is not authorized or able to provide,
   b. Has a physical or other disability that the DUI treatment agency is unable to reasonably accommodate, or
   c. Requires treatment to be provided in a language in which instruction is not provided by the DUI treatment agency; and
2. With written documentation of the reason that the DUI treatment agency is unable to meet the DUI client's treatment needs and a recommendation for additional or alternative DUI treatment that would meet the DUI client's treatment needs.

H. A licensee of an agency that provides DUI treatment shall ensure that a record is maintained for each DUI client that contains:

1. Information and documents received from the screening agency or the referring court regarding the DUI client, if any;
2. The DUI client's assessment and treatment plan required in R9-20-209;
3. Documentation of each group counseling session in which the DUI client participated, including:
   a. The date of the group counseling session,
   b. The topics discussed, and
   c. The DUI client's progress in meeting treatment goals;
4. Documentation of the DUI client's exit interview required in subsection (F)(2);
5. A copy of the report provided to the DUI screening agency or referring court as required in subsection (E); and
6. Documentation of any other written information from or verbal contact with the DUI screening agency or the referring court, if any.

ARTICLE 10. ~~OUTPATIENT SERVICES~~ OPIOID TREATMENT

R9-20-1001. ~~Outpatient Clinic~~ Definitions

~~**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.~~

In addition to the definitions in R9-20-101, the following definitions apply in this Article, unless otherwise specified:

1. "Administrative withdrawal" means a client's detoxification treatment coinciding with the client's involuntary discharge from opioid treatment, typically resulting from non-payment of fees, violent or disruptive behavior, or incarceration or other confinement.
2. "Comprehensive initial assessment" means the collection and analysis of a client's social, medical, and treatment history.
3. "Comprehensive maintenance treatment" means:
   a. Dispensing or administering an opioid agonist treatment medication at stable dosage levels for a period in excess of 21 days to an individual for opioid addiction, and
   b. Providing medical and therapeutic services to the individual with opioid addiction.
4. "Detoxification treatment" means dispensing or administering an opioid agonist treatment medication in decreasing doses to an individual to alleviate adverse physical or psychological effects of withdrawal from the continuous or sustained use of an opioid drug and as a method of bringing the individual to a drug-free state.
5. "Dispense" has the same meaning as in A.R.S. § 32-1901.
6. "Diversion" means the unauthorized transfer of an opioid agonist treatment medication, such as a street sale.
7. "Dosage" means the amount, frequency, and number of doses of medication for an individual.
8. "Dose" means a single unit of opioid agonist treatment medication.

9. "Illicit opiate drug" means an illegally obtained opioid drug that causes addiction and reduces or destroys an individual's physical, social, occupational, or educational functioning, such as heroin.
10. "Intake screening" means determining whether an individual meets the criteria for receiving opioid treatment.
11. "Long-term detoxification treatment" means detoxification treatment for a period of more than 30 days but less than 180 days.
12. "Opioid treatment" means:
    a. Detoxification treatment,
    b. Short-term detoxification treatment,
    c. Long-term detoxification treatment, or
    d. Comprehensive maintenance treatment.
13. "Opioid agonist treatment medication" means a prescription medication, such as methadone or levo-alpha-acetyl-methadol, that is approved by the U.S. Food and Drug Administration under 21 U.S.C. § 355 for use in the treatment of opiate addiction.
14. "Physiologically dependent" means physically addicted to an opioid drug, as manifested by the symptoms of withdrawal in the absence of the opioid drug.
15. "Program sponsor" means the person named in the application for licensure as responsible for the operation of the opioid treatment program and who assumes responsibility for the acts and omissions of staff members or employees of the opioid treatment program.
16. "Short-term detoxification" means detoxification treatment that occurs over a continuous period of 30 days or less.
17. "Take-home medication" means one or more doses of an opioid agonist treatment medication dispensed to a client for use off the premises.

R9-20-1002. ~~Outpatient Rehabilitation Agency~~ Administration

~~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.~~

A program sponsor shall ensure that:

1. The program sponsor designates a physician to serve as medical director and to have authority over all medical aspects of opioid treatment;
2. Written policies and procedures are developed, implemented, complied with, and maintained at the agency and include:
   a. Procedures to prevent a client from receiving opioid treatment from more than one agency or physician concurrently;
   b. Procedures to meet the unique needs of diverse populations, such as pregnant women, children, individuals with HIV or AIDS, or individuals involved in the criminal justice system;
   c. Procedures for relapse prevention;
   d. Procedures for conducting a physical examination, assessment, and laboratory test;

e. Procedures for establishing substance abuse counselor caseloads, based on the intensity and duration of counseling required by each client;
f. Criteria for when the level of opioid agonist treatment medication in a client's blood should be checked and procedures for having the test performed;
g. A requirement that a client who is physiologically dependent as a result of chronic pain receives consultation with or a referral for consultation with a medical practitioner who specializes in chronic pain;
h. Procedures for performing laboratory tests, such as urine drug screens or toxicological tests, including procedures for collecting specimens for testing;
i. Procedures for addressing and managing a client's concurrent abuse of alcohol or other drugs;
j. Procedures for providing take-home medication to clients;
k. Procedures for conducting detoxification treatment;
l. Procedures for conducting an administrative withdrawal;
m. Procedures for voluntary discharge, including a requirement that a client discharged voluntarily be provided or offered follow-up services, such as counseling or a referral for medication for depression or sleep disorders;
n. Procedures to minimize the following adverse events:
   i. A client death,
   ii. A client's loss of ability to function,
   iii. A medication error,
   iv. Harm to a client's family member or another individual resulting from ingesting a client's medication,
   v. Sales of illegal drugs on the premises,
   vi. Diversion of a client's medication,
   vii. Harassment or abuse of a client by a staff member or another client, and
   viii. Violence on the premises;
o. Procedures to respond to an adverse event, including:
   i. A requirement that the program sponsor immediately investigate the adverse event and the surrounding circumstances;
   ii. A requirement that the program sponsor or the program sponsor's designee develop and implement a plan of action to prevent a similar adverse event from occurring in the future; monitor the action taken; and take additional action, as necessary, to prevent a similar adverse event;
   iii. A requirement that action taken under the plan of action be documented; and
   iv. A requirement that the documentation be maintained at the agency for at least two years after the date of the adverse event;
p. Procedures for infection control;
q. Criteria for determining the amount and frequency of counseling that is provided to a client; and
r. Procedures to ensure that the facility's physical appearance is clean and orderly and that facility operations do not impede pedestrian or traffic flow; and

3. A written quality assurance plan is developed and implemented and includes:
   a. Procedures for providing staff members training;
   b. Procedures for developing, administering, and reviewing client satisfaction surveys;
   c. Procedures for monitoring and measuring treatment outcomes;
   d. Procedures to ensure that opioid agonist treatment medications are not diverted or used for purposes other than a client's treatment; and
   e. A requirement that the policies and procedures described in this Section are reviewed and updated, as appropriate, at least once every 12 months.

R9-20-1003. ~~Outpatient Detoxification Services~~ Admission

~~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.~~

A. A program sponsor shall ensure that an individual is only admitted for opioid treatment after an agency medical practitioner determines and documents that:
1. Opioid treatment is medically necessary;
2. The individual meets the definition of opioid dependence contained in the DSM-IV;
3. The individual has received a physical examination as required by subsection (E);
4. If the individual is requesting maintenance treatment, the individual has been physiologically dependent for at least 12 months before the admission, unless the individual receives a waiver of this requirement from an agency physician because the individual:
   a. Was released from a penal institution within the last six months;
   b. Is pregnant, as confirmed by the agency physician;
   c. Was treated for opioid dependence within the last 24 months; or
   d. Is under the age of 18; has had two documented unsuccessful attempts at short-term detoxification or drug-free treatment within a 12-month period; and has consent for treatment from a parent, guardian, or custodian; and
5. If the individual is requesting long-term or short-term detoxification treatment, the individual has not been admitted for detoxification services within the past 12 months.

B. A program sponsor shall ensure that an individual requesting long-term or short-term detoxification treatment who has had two or more unsuccessful detoxification treatment episodes within a 12-month period is assessed by an agency physician for other forms of treatment.

C. An agency physician shall ensure that each client at the time of admission:
1. Provides written, voluntary, agency-specific consent to treatment using one of the following:
   a. U.S. Food and Drug Administration, U.S. Department of Health and Human Services, Form FDA 2635, Consent to Treatment With an Approved Narcotic Drug (July 1993), incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available at http://www.fda.gov/opacom/morechoices/fdaforms/default.html; or
   b. U.S. Food and Drug Administration, U.S. Department of Health and Human Services, Form FDA 2635a, Consentimiento Para El Tratamiento Con Un Narcotico Aprobado (May 1996), incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available at http://www.fda.gov/opacom/morechoices/fdaforms/default.html;
2. Is informed of all services that are available to the client through the agency and of all policies and procedures that impact the client's treatment;
3. Is informed of the following:
   a. The progression of opioid addiction and the client's apparent stage of opioid addiction;
   b. The goal and benefits of opioid treatment;
   c. The signs and symptoms of overdose and when to seek emergency assistance;

d. The characteristics of opioid agonist treatment medication, including common side-effects and potential interaction effects with non-opioid agonist treatment medications or illicit drugs;
e. The requirement for a staff member to report suspected or alleged abuse or neglect of a child or an incapacitated or vulnerable adult according to state law;
f. The requirement for a staff member to comply with the confidentiality requirements of 42 CFR Part 2 (2000), incorporated by reference, on file with the Department and the Office of the Secretary of State, and including no future editions or amendments, available from Government Institutes Division, 4 Research Place, Rockville, MD 20850;
g. Drug screening and urinalysis procedures;
h. Take-home medication requirements;
i. Testing and treatment available for HIV and other communicable diseases; and
j. The client's right to file a grievance with the agency for any reason, including involuntary discharge, and to have the client's grievance handled in a fair and timely manner.

D. A program sponsor shall ensure that a written plan of relapse prevention is developed and implemented for each client admitted for opioid treatment and requires:
1. That the client continue to receive opioid treatment as long as opioid treatment is medically necessary and acceptable to the client;
2. That the client's other behavioral health issues be identified in the client's treatment plan and addressed;
3. If the client is receiving detoxification treatment, that counseling or other behavioral health services be offered to the client;
4. That the client's treatment plan be reviewed and adjusted, if necessary, at the first signs of the client's relapse or impending relapse; and
5. That the client's family members be provided opportunities to be involved in the client's opioid treatment.

E. A program sponsor shall ensure that an agency medical practitioner conducts a physical examination of an individual who requests admission to an agency before the individual receives a dose of opioid agonist treatment medication and that the physical examination includes:
1. Reviewing the individual's bodily systems;
2. Determining whether the individual shows signs of addiction, such as old and fresh needle marks, constricted or dilated pupils, an eroded or perforated nasal septum, or a state of sedation or withdrawal;
3. Evaluating the observable or reported presence of withdrawal signs and symptoms, such as yawning, chills, restlessness, irritability, perspiration, nausea, or diarrhea;
4. Obtaining a medical and family history and documentation of current information to determine chronic or acute medical conditions such as diabetes; renal diseases; hepatitis B, C, or Delta; HIV infection; tuberculosis; sexually transmitted disease; pregnancy; or cardiovascular disease;
5. Obtaining a history of behavioral health issues and treatment, including any diagnoses and medications;
6. Obtaining the following information on the client's family:
   a. The date of birth of the client's children;
   b. Whether the client's children are living with parents;
   c. Family medical history; and
   d. Family history of illicit drug use and alcohol abuse;
7. Initiating the following laboratory tests:
   a. A Mantoux skin test;
   b. A test for syphilis;
   c. A laboratory drug detection test for at least the following:
      i. Opiates;
      ii. Methadone;
      iii. Amphetamines;
      iv. Cocaine;
      v. Barbiturates; and
      vi. Benzodiazepines; and
8. Recommending additional tests based upon the individual's history and physical condition, such as:
   a. Complete blood count;
   b. EKG, chest X-ray, pap smear, or screening for sickle cell disease;
   c. A test for Hepatitis B and C; or
   d. HIV testing.

F. A program sponsor shall ensure that the results of a client's physical examination are documented in the client record.

R9-20-1004. Assessment and Treatment Plan

A. A program sponsor shall ensure that:
1. A client receives an assessment conducted according to the requirements in R9-20-209(A), (C), and (D);

2. An assessment is conducted by a behavioral health professional or a behavioral health technician;
3. A behavioral health professional reviews and approves a client assessment completed by a behavioral health technician to ensure that the assessment is complete and accurate and identifies whether the client may need medical services;
4. An assessment is documented in the client record within seven working days after completing the assessment and includes:
   a. A description of the client's presenting issue;
   b. An identification of the client's behavioral health symptoms and the behavioral health issue or issues that require treatment;
   c. A list of the medical services, including medication, needed by the client, as identified in the physical examination conducted under R9-20-1003(E);
   d. Recommendations for further assessment or examination of the client's needs;
   e. Recommendations for treatment needed by the client, such as counseling;
   f. Recommendations for ancillary services or other services needed by the client;
   g. The signature and date signed, or documentation of the refusal to sign, of the client or the client's guardian or agent or, if the client is a child, the client's parent, guardian, or custodian; and
   h. The signature, professional credential or job title, and date signed of:
      i. The staff member conducting and developing the assessment; and
      ii. If the assessment was completed by a behavioral health technician, the behavioral health professional approving the assessment.

B. A program sponsor shall ensure that a treatment plan is developed for each client and that the treatment plan is:
1. Based upon the results of the client's physical examination and assessment;
2. Developed by a behavioral health professional or a behavioral health technician;
3. Developed with the participation of the client, the client's guardian, or the client's agent or, if the client is a child, the client's parent, guardian, or custodian;
4. If the treatment plan was completed by a behavioral health technician, reviewed and approved by a behavioral health professional to ensure that the treatment plan is complete and accurate and meets the client's treatment needs;
5. Documented in the client record within seven working days after completion, to include:
   a. The client's presenting issue;
   b. One or more treatment goals;
   c. One or more treatment methods and the frequency of each treatment method;
   d. The date when the client's treatment plan will be reviewed;
   e. The method and frequency of communicating the client's progress to:
      i. The client;
      ii. The client's parent, guardian, custodian, agent, family member, or designated representative;
      iii. The individual who coordinates behavioral health services and ancillary services for the client; and
      iv. Other agencies, individuals, or entities that provide treatment to the client;
   f. If a discharge date has been determined, the treatment needed after discharge;
   g. The signature and date signed, or documentation of the refusal to sign, of the client or the client's guardian or agent or, if the client is a child, the client's parent, guardian, or custodian; and
   h. The signature, professional credential or job title, and date signed of:
      i. The staff member conducting and developing the treatment plan; and
      ii. If the treatment plan was completed by a behavioral health technician, the behavioral health professional approving the treatment plan; and
6. Reviewed and updated on an on-going basis:
   a. According to the review date specified in the treatment plan,
   b. When a treatment goal is accomplished or changes,
   c. When additional information that affects the client's assessment is identified,
   d. When a client has a significant change in condition or experiences an event that affects treatment, and
   e. At least once every three months during the client's first year of opioid treatment and at least once every six months after the client's first year of opioid treatment.

R9-20-1005. Dosage

A. A program sponsor shall ensure that:
1. A dose of opioid agonist treatment medication is administered only after an order from a medical practitioner;
2. A client's dosage of opioid agonist treatment medication is individually determined;
3. A dose of opioid agonist treatment medication is sufficient to produce the desired response in a client for the desired duration of time and with consideration for client safety;
4. A dose of opioid medication is prescribed to meet a client's treatment needs by:

a. Preventing the onset of subjective or objective signs of withdrawal for 24 hours or more;
b. Reducing or eliminating the drug craving that is experienced by opioid addicted individuals who are not in opioid treatment; and
c. Blocking the effects of any self-administered opioid drugs without inducing persistent euphoric or other undesirable effects that are reported by the client or observed by other individuals;

5. A client receiving comprehensive maintenance treatment receives an initial dose of opioid agonist treatment medication based upon the medical practitioner's physical examination and with consideration for local issues, such as the relative purity of available illicit opioid drugs;
6. A client receiving methadone in comprehensive maintenance treatment receives an initial dose of methadone that does not exceed 30 milligrams and:
   a. If the client's withdrawal symptoms are not suppressed three hours after the initial dose of 30 milligrams, a client receives an additional dose that does not exceed 10 milligrams only if an agency nurse documents in the client record that 30 milligrams did not suppress the client's withdrawal symptoms; and
   b. If the client's withdrawal symptoms are not suppressed by a total dose of 40 milligrams, a client receives an additional dose only if an agency physician documents in the client record that 40 milligrams did not suppress the client's withdrawal symptoms;
7. A client receiving levo-alpha-acetyl-methadol in comprehensive maintenance treatment receives an initial dose according to the instructions on the opioid agonist treatment medication package insert, and any deviation from the instructions is documented by the medical practitioner in the client record; and
8. A client receives subsequent doses of opioid agonist treatment medication:
   a. Based on the client's individual needs and the results of the physical examination and assessment;
   b. Sufficient to achieve the desired response for at least 24 hours, with consideration for day-to-day fluctuations and elimination patterns;
   c. That are not used to reinforce positive behavior or punish negative behavior;
   d. As long as the client benefits from and desires comprehensive maintenance treatment; and
   e. That are adjusted if an agency changes from one type of opioid agonist treatment medication to another.

R9-20-1006. Drug Screening

A program sponsor shall ensure that:

1. Staff members have knowledge of the benefits and limitations of laboratory drug detection tests and other toxicological testing procedures;
2. At least eight random laboratory drug detection tests are completed each year for a client in comprehensive maintenance treatment, and other toxicological tests are performed according to written orders from a medical practitioner;
3. Laboratory drug detection tests and other toxicological testing specimens are collected in a manner that minimizes falsification;
4. Samples from laboratory drug detection tests are tested for:
   a. Opiates;
   b. Methadone;
   c. Amphetamines;
   d. Cocaine;
   e. Barbiturates;
   f. Benzodiazepines; and
   g. Other substances based upon the client record; and
5. The results of a client's laboratory drug detection tests or other toxicological test and any action taken relating to the results are documented in the client record.

R9-20-1007. Take-Home Medication

A. A program sponsor shall ensure that policies and procedures are developed, implemented, and complied with for the use of take-home medication and include:
   1. Criteria for determining when a client is ready to receive take-home medication;
   2. Criteria for when a client's take-home medication is increased or decreased;
   3. A requirement that take-home medication be dispensed according to federal and state law;
   4. A requirement that a medical practitioner review a client's take-home medication regimen at intervals established in the client's treatment plan and adjust the client's dosage, as needed;
   5. Procedures for safe handling and secure storage of take-home medication in a client's home; and
   6. Criteria and duration of allowing a physician to prescribe a split medication regimen.

B. Except as provided in subsection (C), a program sponsor shall ensure that a client is permitted to have take-home medication only upon the determination and written permission of the agency medical director, based upon the following:
   1. Absence of abuse of drugs, including alcohol;

2. Regularity of agency attendance;
3. Length of time in comprehensive maintenance treatment;
4. Absence of criminal activity;
5. Absence of serious behavioral problems at the agency;
6. Special needs of the client such as physical health needs;
7. Assurance that take-home medication can be safely stored in the client's home;
8. Stability of the client's home environment and social relationships;
9. The client's work, school, or other daily activity schedule;
10. Hardship experienced by the client in traveling to and from the agency; and
11. Whether the benefit the client would receive by decreasing the frequency of agency attendance outweighs the potential risk of diversion.

C. A client in comprehensive maintenance treatment may receive a single dose of take-home medication for each day that an agency is closed for business, including Sundays and state and federal holidays.

D. A program sponsor shall ensure that take-home medication is only issued to a client in compliance with the following restrictions:
1. During the first 90 days of comprehensive maintenance treatment, a client may receive take-home medication as described in subsection (C);
2. During the second 90 days of comprehensive maintenance treatment, a client may receive a maximum of one dose of take-home medication each week in addition to any doses received as described in subsection (C);
3. During the third 90 days of comprehensive maintenance treatment, a client may receive a maximum of two doses of take-home medication each week in addition to any doses received as described in subsection (C);
4. In the remaining months of the client's first year, a client may receive a maximum of three doses of take-home medication each week in addition to any doses received as described in subsection (C);
5. After one year of comprehensive maintenance treatment, a client may receive a maximum of six doses of take-home medication for each week;
6. After two years of comprehensive maintenance treatment, a client may receive a maximum of 14 doses of take-home medication every two-weeks; and
7. After three years of comprehensive maintenance treatment, a client may receive a maximum of 31 doses of take-home medication for a month, but shall visit the agency at least once each month.

E. A program sponsor shall ensure that a client receiving take-home medication receives:
1. Take-home medication in a child-proof container; and
2. Written and verbal information on the client's responsibilities in protecting the security of take-home medication.

F. The program sponsor shall ensure that a medical director's determination made under subsection (B) and the reasons for the determination are documented in the client record.

R9-20-1008. Detoxification Treatment

A licensee shall ensure that:
1. Policies and procedures are developed, implemented, and complied with for detoxification treatment and:
   a. Are designed to promote successful detoxification treatment;
   b. Require that dose reduction occur at a rate well tolerated by the client;
   c. Require that a variety of ancillary services, such as self-help groups, be available to the client through the agency or through referral;
   d. Require that the amount of counseling available to the client be increased before discharge; and
   e. Require that a client be re-admitted to the agency or referred to another agency if relapse occurs;
2. A client's detoxification treatment:
   a. For a client involved in comprehensive maintenance treatment, is only initiated as administrative withdrawal or when requested by the client and approved by an agency medical practitioner; and
   b. Is planned and supervised by an agency medical practitioner;
3. Before a client begins detoxification treatment, whether with or against the advice of an agency medical practitioner, the client:
   a. Is informed by an agency medical practitioner or a staff member:
      i. That the client has the right to leave opioid treatment at any time, and
      ii. Of the risks of detoxification treatment; and
   b. Receives a schedule for detoxification treatment that is developed by an agency medical practitioner with input from the client;
4. If a client who is receiving detoxification treatment, other than a client experiencing administrative withdrawal, appears to a staff member to relapse, the client is permitted to begin comprehensive maintenance treatment, if otherwise eligible;
5. If a client who has completed detoxification treatment within the past 30 days appears to a staff member to relapse, the client is re-admitted into the agency without a physical examination or assessment;

6. A client experiencing administrative withdrawal is referred or transferred to an agency that is capable of or more suitable for meeting the client's needs, and the referral or transfer is documented in the client record; and
7. The following information is documented in the client record:
   a. The reason that the client sought detoxification treatment or was placed on administrative withdrawal; and
   b. The information and assistance provided to the client in detoxification treatment or administrative withdrawal.

R9-20-1009. Counseling and Medical Services

A. A program sponsor shall ensure that:
1. Counseling is provided to each client based upon the client's individual needs and treatment plan; and
2. The agency has substance abuse counselors in a number sufficient:
   a. To ensure that clients have access to counselors,
   b. To provide the treatment in clients' treatment plans, and
   c. To provide unscheduled treatment or counseling to clients.

B. A program sponsor shall ensure that a client has access to a self-help group or support group, such as Narcotics Anonymous, either at the agency or through referral to a community group.

C. A program sponsor shall ensure that a client is provided medical services, including psychiatric services, if needed, either at the agency or through referral. If a client receives medical services, including psychiatric services, from a person not affiliated with the agency, agency staff members shall communicate and coordinate with the person that provides medical services to the client, according to the requirements for the release of client records or information in R9-20-211(A)(3).

R9-20-1010. Diverse Populations

A. A program sponsor shall ensure that:
1. Opioid treatment is provided regardless of race, ethnicity, gender, age, or sexual orientation;
2. Opioid treatment is provided with consideration for a client's individual needs, cultural background, and values;
3. Agency staff members are culturally competent;
4. Unbiased language is used in the agency's print materials, electronic media, and other training or educational materials;
5. HIV testing and education are available to clients either at the agency or through referral;
6. A client who is HIV-positive and who requests treatment for HIV or AIDS:
   a. Is offered treatment for HIV or AIDS either at the agency or through referral, and
   b. Has access to an HIV- or AIDS-related peer group or support group and to social services either at the agency or through referral to a community group; and
7. The agency has a procedure for transferring a client's opioid treatment to the medical practitioner treating the client for HIV or AIDS when HIV or AIDS becomes the client's primary health concern.

B. A program sponsor shall ensure that:
1. An individual who requires administration of opioid agonist treatment medication only for relief of chronic pain is:
   a. Identified during the physical examination or assessment,
   b. Not admitted for opioid agonist medication treatment, and
   c. Referred for medical services; and
2. A client with a chronic pain disorder who is also physically dependent is treated by a multi-disciplinary team of medical practitioners that includes specialists in addiction medicine and pain management.

C. A program sponsor shall ensure that:
1. A client who may have a mental disorder is identified during the physical examination or assessment,
2. A client who may have a mental disorder is referred for treatment for the mental disorder, and
3. The agency has a procedure to communicate and collaborate with a client's behavioral health professional to monitor and evaluate interactions between the client's opioid agonist treatment medication and medications used to treat the client's mental disorder.

D. A program sponsor shall ensure that a policy and procedure is developed, implemented, and complied with for the treatment of female clients, to include:
1. A requirement that staff members be educated in the unique needs of female clients,
2. A requirement that each female client be informed about or referred to a same sex support group at the agency or in the community, and
3. A requirement that breast feeding be encouraged during comprehensive maintenance treatment unless medically contraindicated.

E. A program sponsor shall ensure that a policy and procedure is developed, implemented, and complied with for the treatment of pregnant clients, to include:
1. A requirement that priority be given to pregnant individuals seeking opioid treatment;
2. A requirement that the reasons for a pregnant individual's denial of admission to an agency be documented;

3. A requirement that a pregnant client be offered prenatal care either at the agency or through referral to a medical practitioner;
4. A requirement that the agency establish a written agreement with a medical practitioner who is providing prenatal care to a pregnant client, to include a procedure for exchanging opioid treatment and prenatal care information in accordance with R9-20-211(A)(3);
5. A requirement that a staff member educate a pregnant client who does not obtain prenatal care services on prenatal care;
6. A requirement that a staff member obtain a written refusal of prenatal care services from a pregnant client who refuses prenatal care services offered by the agency or a referral for prenatal care;
7. A requirement that a pregnant client receiving comprehensive maintenance treatment before pregnancy be maintained at the pre-pregnancy dose of opioid agonist medication, if effective, and that the dosage requirements of R9-20-1005 be applied;
8. A requirement that dosage requirements in R9-20-1005 be followed for a pregnant client's initial and subsequent doses of opioid agonist treatment medication;
9. A requirement that a pregnant client be monitored by an agency medical practitioner to determine if pregnancy induced changes in the elimination or metabolization of opioid agonist treatment medication may necessitate an increased or split dose;
10. A requirement that detoxification treatment not be initiated before 14 weeks or after 32 weeks of gestation and that a pregnant client receiving detoxification treatment be referred to a medical practitioner for supervision of withdrawal that includes fetal assessments; and
11. A requirement that a pregnant client discharged from the agency be referred to a medical practitioner and that a staff member document the name, address, and telephone number of the medical practitioner in the client record.

F. A program sponsor shall ensure that:
1. Agreements and procedures are established with the criminal justice system to allow the agency to continue providing opioid treatment to clients who are incarcerated, on probation, or on parole; and
2. Staff members advocate to the criminal justice system for continuous opioid treatment for clients who are incarcerated, on probation, or on parole.

R9-20-1011. Preparedness Planning

A. A program sponsor shall ensure that:
1. The program sponsor has a written agreement with at least one other agency for the provision of opioid agonist treatment medication to agency clients in the event that the agency is unable to provide services,
2. An agency has 24-hour telephone answering service, and
3. A list of all clients and the clients' dosage requirements is available and accessible to agency on-call staff members.

B. A program sponsor shall ensure that a written plan is developed and implemented for continuity of client services if the agency is voluntarily or involuntarily closed and:
1. Includes steps for the orderly transfer of clients to other agencies, individuals, or entities that provide opioid treatment;
2. Includes procedures for securing, maintaining, and transferring client records according to federal and state law; and
3. Is reviewed and updated, as appropriate, at least once every 12 months.

R9-20-1012. Client Records

A program sponsor shall ensure that client records are maintained in compliance with R9-20-211 and that each client record includes:
1. The results of the physical examination conducted according to R9-20-1003(C);
2. The results of the assessment conducted according to R9-20-1004;
3. The results of laboratory tests and a description of any action taken based upon the results;
4. Documentation of the client's current dose and dosage history;
5. Documentation of counseling provided to the client;
6. Dates and results of meetings or conferences regarding the client's treatment;
7. Documentation of the process used and factors considered in making decisions that impact a client's treatment, such as whether to allow take-home medication and the frequency of laboratory drug detection tests; and
8. Documentation of the agency's efforts to learn of multiple opioid treatment program enrollment.

R9-20-1013. Community Relations

A. A program sponsor shall ensure that policies and procedures are developed, implemented, and complied with to educate the community about opioid treatment and to promote understanding in the surrounding community and include:
1. A mechanism for eliciting input from the community about the agency's impact on the community,
2. A requirement that the program sponsor or designee interface with community leaders to foster positive relations,

3. A requirement that the program sponsor or designee establish a liaison with community representatives to share information about the agency,
4. A requirement that the agency have information on substance abuse and related health and social issues available to the public, and
5. A mechanism for addressing and resolving community concerns about opioid treatment or the agency's presence in the community.

B. A program sponsor shall ensure that community relations efforts are documented and are evaluated at least once every 12 months.

R9-20-1014. Diversion Control

A program sponsor shall ensure that a written plan is developed, implemented, and complied with to prevent diversion of opioid agonist treatment medication from its intended purpose to illicit use and that the written plan includes:

1. Procedures to hold staff members accountable for diversion,
2. A requirement that treatment and administrative activities be continuously monitored to reduce the risk of diversion, and
3. A procedure for stopping identified diversion and for preventing future diversion.

ARTICLE 11. ~~BEHAVIORAL HEALTH CASE MANAGEMENT AGENCY~~ MISDEMEANOR DOMESTIC VIOLENCE OFFENDER TREATMENT

R9-20-1101. ~~Behavioral Health Case Management Agency~~ Misdemeanor Domestic Violence Offender Treatment Standards

~~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.~~

A. A licensee of an agency that provides misdemeanor domestic violence offender treatment shall ensure that:

1. The agency's program description includes, in addition to the items listed in R9-20-201(A)(2), the agency's method for providing misdemeanor domestic violence offender treatment;
2. The agency's method for providing misdemeanor domestic violence offender treatment:
    a. Is professionally recognized treatment for which supportive research results have been published within the five years before the date of application for an initial or renewal license;
    b. Does not emphasize or exclusively include one or more of the following:
        i. Anger or stress management,
        ii. Conflict resolution,
        iii. Family counseling, or
        iv. Education or information about domestic violence;
    c. Emphasizes personal responsibility;
    d. Identifies domestic violence as a means of asserting power and control over another individual;
    e. Does not require the participation of a victim of domestic violence;
    f. Includes individual counseling, group counseling, or a combination of individual counseling and group counseling according to the requirements in R9-20-302; and
    g. Does not include more than 15 clients in group counseling; and
3. Misdemeanor domestic violence offender treatment is not provided at a location where a victim of domestic violence is sheltered.

B. A licensee of an agency that provides misdemeanor domestic violence offender treatment shall ensure that, for each referring court, a policy and procedure is developed, implemented, and complied with for providing misdemeanor domestic violence offender treatment that:

1. Establishes:
    a. The process for a client to begin and complete misdemeanor domestic violence offender treatment;
    b. The timeline for a client to begin misdemeanor domestic violence offender treatment;
    c. The time-line for a client to complete misdemeanor domestic violence offender treatment, which shall not exceed 12 months; and
    d. Criteria for a client's successful completion of misdemeanor domestic violence offender treatment, including attendance, conduct, and participation requirements;
2. Requires the licensee that provides misdemeanor domestic violence offender treatment to notify a client at the time of admission of the consequences to the client, imposed by the referring court or the licensee, if the client fails to successfully complete misdemeanor domestic violence offender treatment;
3. Requires the licensee to notify the referring court in writing within a timeline established with the referring court when any of the following occur:
    a. The licensee determines that a client referred by the referring court has not reported for admission to the misdemeanor domestic violence offender treatment program,

b. The licensee determines that a client referred by the referring court is ineligible or inappropriate for the agency's misdemeanor domestic violence offender treatment program,
c. A client is admitted to the agency's misdemeanor domestic violence offender treatment program,
d. A client is voluntarily or involuntarily discharged from the agency's misdemeanor domestic violence offender treatment program,
e. A client fails to comply with misdemeanor domestic violence offender treatment, or
f. A client completes misdemeanor domestic violence offender treatment;
4. Is reviewed by the referring court before the agency provides misdemeanor domestic violence offender treatment;
5. Requires that the referring court's review be documented, to include:
a. The date of the review;
b. The name and title of the individual performing the review for the referring court; and
c. Changes to the policy and procedure requested by the referring court, if applicable;
6. Requires the licensee to contact the referring court at least once every 12 months after the date the licensee begins to provide misdemeanor domestic violence offender treatment to determine whether the referring court has made any changes in its procedures or requirements that necessitate changes to the licensee's policy and procedure;
7. Is reviewed and revised as necessary by the licensee at least once every 12 months; and
8. Is maintained at the agency.

C. A licensee of an agency that provides misdemeanor domestic violence offender treatment shall ensure that misdemeanor domestic violence offender treatment is provided by a staff member who:
1. Is either:
a. A behavioral health professional, or
b. A behavioral health technician with at least an associate's degree;
2. Satisfies one of the following:
a. Has at least six months of full-time work experience with domestic violence offenders or other criminal offenders, or
b. Is visually observed and directed by a staff member with at least six months of full-time work experience with domestic violence offenders or other criminal offenders; and
3. Has completed at least 40 hours of education or training in one or more of the following areas within the four years before the date the individual begins providing misdemeanor domestic violence offender treatment:
a. Domestic violence offender treatment,
b. The dynamics and impact of domestic violence and violent relationships, or
c. Methods to determine an individual's potential to harm the individual or another.

D. A licensee of an agency that provides misdemeanor domestic violence offender treatment shall ensure that:
1. In addition to meeting the training requirements in R9-20-206(B), a staff member completes at least eight hours of training, every 12 months after the staff member's starting date of employment or contract service, in one or more of the areas listed in subsection (C)(3); and
2. Training required in this Section is documented according to R9-20-206(B)(4).

E. A licensee of an agency that provides misdemeanor domestic violence offender treatment shall ensure that a staff member completes an assessment of each client that includes, in addition to the requirements of R9-20-209, the following:
1. Obtaining the case number or identification number assigned by the referring court;
2. Determining whether the client has any past or current orders for protection or no-contact orders issued by a court;
3. Obtaining the client's history of domestic violence or family disturbances, including incidents that did not result in arrest;
4. Obtaining the details of the misdemeanor domestic violence offense that led to the client's referral for misdemeanor domestic violence offender treatment; and
5. Determining the client's potential to harm the client or another.

F. A licensee of an agency that provides misdemeanor domestic violence offender treatment shall ensure that a client who has completed misdemeanor domestic violence offender treatment receives a certificate of completion that includes:
1. The case number or identification number assigned by the referring court;
2. The client's name;
3. The date of completion of misdemeanor domestic violence offender treatment;
4. The name, address, and telephone number of the agency providing misdemeanor domestic violence offender treatment; and
5. The signature of an individual authorized to sign on behalf of the licensee.

G. A licensee of an agency that provides misdemeanor domestic violence offender treatment shall:
1. Provide the original of a client's certificate of completion to the referring court according to the timeline established in the licensee's policy and procedure,
2. Provide a copy of the client's certificate of completion to the client, and
3. Maintain a copy of the client's certificate of completion in the client record.

R9-20-1102. ~~Service Requirements for Case Management Agencies~~ Repealed

~~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 case load.~~
~~H. Case management and case coordination services shall be staffed to acuity and shall be limited if the case load 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).~~

ARTICLE 12. ~~ASSESSMENT, EVALUATION, AND DIAGNOSIS SERVICE AGENCIES~~ LEVEL 4 TRANSITIONAL AGENCY

R9-20-1201. ~~Assessment, Evaluation, and Diagnosis Service Agency~~ Definitions

~~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.~~

The following definitions apply in this Article unless otherwise specified:
  1. "Client profile" means documentation of a client's individual information and goals.
  2. "Substance abuse program" means a self-help group, such as Alcoholics Anonymous or Narcotics Anonymous or a peer support group.
  3. "Supportive intervention" means interaction between a client and a Level 4 transitional staff member to assist the client in addressing a behavioral health issue, a crisis situation, or another behavioral health need.

R9-20-1202. Standards for a Level 4 Transitional Agency

A. A licensee of a Level 4 transitional agency shall:
  1. Ensure that the licensee complies with this Article and applicable federal, state, and local law;
  2. Ensure that a record, report, or document required to be maintained by this Article or applicable federal, state, or local law is provided to the Department as soon as possible upon request and no later than:
    a. Two hours after the time of a request for a client currently receiving behavioral health services at the agency, or
    b. Three working days after the time of a request for a client discharged from the agency;
  3. Adopt and maintain a current program description that:

a. Meets the requirements in R9-20-201(A)(2), and
b. Identifies whether the Level 4 transitional agency provides a substance abuse program at the facility;
4. Develop, implement, and comply with policies for a client's use and occupancy of the Level 4 transitional agency;
5. Designate a manager who:
a. Has the authority and responsibility to operate the Level 4 transitional agency according to the requirements in this Article;
b. Is at least 21 years old;
c. Has one of the following:
i. A bachelor's degree and at least one year of full-time behavioral health work experience or part-time behavioral health work experience equivalent to one year of full-time behavioral health work experience;
ii. An associate's degree and at least two years of full-time behavioral health work experience or part-time behavioral health work experience equivalent to two years of full-time behavioral health work experience; or
iii. A high school diploma or a high school equivalency diploma and at least four years of full-time behavioral health work experience or part-time behavioral health work experience equivalent to four years of full-time behavioral health work experience; and
d. Has access to all areas of the premises;
6. Ensure that a manager designates in writing a Level 4 transitional staff member who:
a. Is not a client;
b. Is required to be present at the Level 4 transitional agency and in charge of operations when the manager is not present and clients are on the premises; and
c. Has access to all areas of the premises;
7. Ensure that at the time of admission, a client receives written notice of all fees that the client is required to pay and of the Level 4 transitional agency's refund policy;
8. Notify a client at least 30 days before changing a fee that the client is required to pay by:
a. Conspicuously posting a notice of the fee change in the facility, or
b. Providing written notification to each client;
9. Develop, implement, and comply with a grievance policy and procedure that includes the steps and timeline for responding to and resolving client grievances;
10. Conspicuously post the following information in the Level 4 transitional agency:
a. A list of the client rights in subsection (B);
b. The grievance policy and procedure;
c. The policies for a client's use and occupancy of the Level 4 transitional agency; and
d. The current telephone number and address for:
i. The OBHL;
ii. The Arizona Department of Economic Security Office of Adult Protective Services or Office of Child Protective Services, as applicable;
iii. 911 or another local emergency response team; and
iv. A poison control center; and
11. Ensure that the requirements for required reports in R9-20-202 are met.

B. A licensee shall ensure that a client is afforded the following rights:
1. To be treated with dignity, respect, and consideration;
2. To receive services at the Level 4 transitional agency without discrimination based upon race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, legal status, or method of payment;
3. To submit grievances without restraint or retaliation and have grievances considered in a fair, timely, and impartial manner;
4. To have information and records kept confidential;
5. To have privacy in correspondence, communication, visitation, and financial affairs;
6. To review the client's own record;
7. To be informed at the time of admission of all fees that the client is required to pay and to receive at least 30-day's notice before a change in a fee that the client is required to pay; and
8. To be free from abuse and exploitation.

C. A licensee of a Level 4 transitional agency shall ensure that:
1. A manager or Level 4 transitional staff member:
a. Is at least 21 years old;
b. Has current documented successful completion of first-aid and CPR training specific to adults that included a demonstration of the individual's ability to perform CPR;
c. Has skills and knowledge in providing a supportive intervention; and

d. At the starting date of employment and every 12 months after the starting date of employment, submits one of the following as evidence of freedom from infectious pulmonary tuberculosis:
   i. A report of a negative Mantoux skin test administered within six months before submitting the report; or
   ii. If the individual has had a positive skin test for tuberculosis, a written statement from a medical practitioner, dated within six months before submitting the statement, indicating freedom from infectious pulmonary tuberculosis;

2. There are a sufficient number of Level 4 transitional staff members to meet the requirements of this Article;
3. At least the manager or one Level 4 transitional staff member is present on the premises when a client is at the facility;
4. The agency has a daily staffing schedule that:
   a. Indicates the date, scheduled work hours, and name of each Level 4 transitional staff member assigned to work;
   b. Includes documentation of the Level 4 transitional staff members who work each day and the hours worked by each; and
   c. Is maintained on the premises or at the administrative office for at least 12 months after the last date on the documentation; and
5. For the manager and each Level 4 transitional staff member, a record is maintained that:
   a. Includes documentation of the manager's or staff member's compliance with the requirements in this Section, and
   b. Is maintained on the premises or at the administrative office throughout the manager's or Level 4 transitional staff member's period of employment and for at least two years after the manager's or Level 4 transitional staff member's last date of employment.

D. A licensee shall ensure that:
1. An individual is admitted into and served by the Level 4 transitional agency based upon:
   a. The individual's presenting issue and needs, consistent with the services that the Level 4 transitional agency is authorized and able to provide;
   b. The agency's criteria for admission contained in the agency's program description required in subsection (A)(3); and
   c. The applicable requirements in federal and state law and this Chapter;
2. An individual admitted to or served by the Level 4 transitional agency:
   a. Is not a danger to self or a danger to others; and
   b. Does not require behavioral health services, medical services, or ancillary services that the agency is not authorized or able to provide;
3. If a client or other individual does not meet the criteria in subsection (D)(1) or (2), the client or other individual is provided with a referral to another agency or entity; and
4. Before a client is admitted to a Level 4 transitional agency, the client signs and dates a written consent form.

E. A licensee shall ensure that within five days after the date of a client's admission, a written client profile is completed that includes:
1. The client's name and date of birth;
2. The name and telephone number of:
   a. An individual to contact in case of an emergency;
   b. The client's parent, guardian, custodian, or agent, if applicable;
   c. The individual who coordinates the client's behavioral health services or ancillary services, if applicable; and
   d. The client's probation or parole officer, if applicable;
3. The client's reason for seeking admission to the Level 4 transitional agency;
4. The client's history of behavioral health issues and treatment;
5. A list of medication the client is currently taking;
6. The client's medical service needs, including allergies;
7. The client's substance abuse history and current pattern of substance use;
8. Whether the client has a physical or other disability;
9. The client's past and current involvement in the criminal justice system;
10. The client's goal or desired outcome while living at the Level 4 transitional agency;
11. The client's intended method of achieving the client's goals while living in the Level 4 transitional agency; and
12. The client's signature and date signed.

F. A licensee may provide a client with a locked area or locked container in which to secure the client's medication if the client:
1. Is independent in self-administering medication and does not require any of the following:
   a. A reminder to take medication,
   b. Assurance that the client is taking medication as directed by the client's medical practitioner, or

c. Assistance opening a medication container; and
2. Has access to the client's medication at all times.

G. A licensee shall ensure that a client record is maintained that:
1. Meets the requirements of R9-20-211(A); and
2. Contains:
a. Documentation of the client's receipt of a list of the client rights in subsection (B);
b. The consent form signed by the client as required in subsection (D)(4);
c. The client profile required in subsection (E);
d. The dates the client was admitted to and, if applicable, discharged from the Level 4 transitional agency; and
e. Documentation of any telephone, written, or face-to-face contacts that relate to the client's health, safety, or welfare.

H. A licensee shall ensure that a facility used as a Level 4 transitional agency:
1. Complies with:
a. The fire safety requirements of the local jurisdiction,
b. R9-20-406, and
c. R9-20-214;
2. Contains a working telephone;
3. Contains a common area that is not used as a sleeping area and a dining area that is not used as a sleeping area;
4. Has a bathroom that contains:
a. For every six clients, at least one working toilet that flushes and has a seat and one sink with running water;
b. For every eight clients, at least one working bathtub or shower, with a slip resistant surface;
c. Lighting;
d. Hot and cold running water; and
e. An openable window or other means of ventilation;
5. Has an area, capable of being locked, for each client's personal belongings; and
6. Has bedrooms that are constructed and furnished to provide unimpeded access to the door and that each provide at least two means of exit in an emergency.

ARTICLE 13. ~~SHELTERS; HALFWAY HOUSES~~ SHELTER FOR VICTIMS OF DOMESTIC VIOLENCE

R9-20-1301. ~~Shelters; Shelter Services~~ Standards for a Shelter for Victims of Domestic Violence

~~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.~~

A licensee of a shelter for victims of domestic violence shall comply with:
1. The requirements for a Level 4 transitional agency in Article 12; and
2. The applicable requirements in A.R.S. Title 36, Chapter 30, including requirements for:
a. Fingerprinting of personnel according to A.R.S. § 36-3008; and
b. Ensuring, according to A.R.S. § 36-3009, that the location of a shelter for victims of domestic violence is not disclosed.

R9-20-1302. ~~Manager Qualifications and Responsibilities~~ Repealed

~~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.~~

R9-20-1303. ~~Staffing Requirements~~ Repealed

~~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.~~

R9-20-1304. ~~Residency Requirements~~ Repealed

~~Shelter residency shall be in accordance with the client's individualized service plan and the agency's policies.~~

~~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.~~

R9-20-1306. ~~Required Recordkeeping~~ Repealed

~~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.~~

R9-20-1307. ~~Fire and Safety~~ Repealed

~~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.~~

R9-20-1308. ~~Halfway Houses; Halfway House Services~~ Repealed

~~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.~~

R9-20-1309. ~~Manager Qualifications and Responsibilities~~ Repealed

~~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.~~

R9-20-1310. ~~Staffing Requirements~~ Repealed

~~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.~~

R9-20-1311. ~~Residency Requirements~~ Repealed

~~Halfway house residency must be in accordance with the client's individualized service plan and the agency's policies.~~

R9-20-1312. ~~Environmental Standards~~ Repealed

~~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.~~

R9-20-1313. ~~Required Recordkeeping~~ Repealed

~~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.~~

R9-20-1314. ~~Fire and Safety~~ Repealed

~~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.~~

ARTICLE 14. ~~PRE-PETITION SCREENING; COURT- ORDERED SERVICES~~ RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY

R9-20-1401. ~~Pre-petition Screening~~ Standards for a Rural Substance Abuse Transitional Agency

~~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.~~

A. A licensee of a rural substance abuse transitional agency shall comply with the requirements for a Level 4 transitional agency in Article 12.
B. A licensee of a rural substance abuse transitional agency shall ensure that staffing is provided as follows:
   1. A written memorandum of understanding is established, implemented, and complied with to ensure that immediate contact with a licensed hospital is available to ensure the need for a higher or more acute level of care is determined and transportation is obtained;
   2. A behavioral health professional is present at the agency or on-call at all times; and
   3. A Level 4 transitional staff member is present and awake at the agency at all times who:
      a. Has current documented successful completion of first-aid and CPR training specific to the populations served by the agency, such as children or adults, that included a demonstration of the staff member's ability to perform CPR;
      b. Has documented training and skills and knowledge in providing a supportive intervention and in recognizing and responding to the medical conditions and complications associated with substance abuse; and
      c. Is an emergency medical technician.
C. A licensee shall ensure that:
   1. A rural substance abuse transitional agency:
      a. Is open at all times;
      b. Develops, implements and complies with criteria to determine when emergency transportation is needed; and
      c. Provides an individual with a written referral to an agency or entity that can provide the behavioral health services or medical services that the individual needs and that the rural substance abuse transitional agency is not authorized or able to provide;
   2. Within 24 hours after a client's admission to the rural substance abuse transitional agency, a Level 4 transitional agency staff member:
      a. Collects and documents information on the client's medical, social, and substance abuse status and history;

b. Consults with an agency registered nurse or behavioral health professional to determine whether the client has a substance abuse problem and, if so, the behavioral health services that will be provided to the client for the period of time that the client is expected to remain at the rural substance abuse transitional agency;
c. Develops a written description of the specific behavioral health services that will be provided to the client to meet the client's needs for the period of time that the client is at the agency; and
d. Provides a client with an assessment completed by a medical practitioner, registered nurse, or emergency medical technician within 24 hours after the client's admission; and
3. A client receives continuous supervision, supportive intervention, and periodic monitoring of the client's vital signs to ensure the client's health, safety, and welfare.

R9-20-1402. ~~Court-ordered Mental Health Evaluation and Treatment~~ Repealed

~~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.~~

R9-20-1403. ~~Court-ordered Alcoholism Treatment Services~~ Repealed

~~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.~~

ARTICLE 15. ~~REPEALED~~ ADULT THERAPEUTIC FOSTER HOME

R9-20-1501. ~~Repealed~~ Management

A. A licensee or sponsor of an adult therapeutic foster home is responsible for the organization and management of the adult therapeutic foster home and shall ensure compliance with:
1. This Article;
2. Applicable federal, state, and local law;
3. R9-20-202;
4. R9-20-203;
5. R9-20-204(H)(2);
6. R9-20-210;
7. R9-20-212;
8. R9-20-214(A) and (C) through (H);
9. R9-20-403;
10. R9-20-405;
11. R9-20-406; and
12. If the adult therapeutic foster home is authorized to provide assistance in the self-administration of medication, R9-20-408.

B. A licensee or sponsor of an adult therapeutic foster home shall have in place and comply with written policies and procedures for:
1. Ensuring the health, safety, and welfare of a client on the premises or participating in an agency-sponsored activity off the premises;
2. Maintaining client records and information;
3. Protecting the confidentiality of client records and information;
4. Reporting and investigating incidents listed in R9-20-202(A);
5. Ensuring the security of possessions that a client brings to the adult therapeutic foster home;
6. Smoking on the premises;
7. Ensuring communication and coordination, consistent with the release of information requirements in R9-20-211(A)(3), with:
a. A client's family member, guardian, custodian, designated representative, or agent;
b. The individual who coordinates the client's behavioral health services or ancillary services, if applicable; and
c. Other entities or individuals from whom the client may receive treatment, medical services, or other services;
8. Responding to a client's medical emergency or immediate need for unscheduled behavioral health services; and

9. Responding to a client's threat of imminent serious physical harm or death to a clearly identified or identifiable individual.

C. A licensee or sponsor of an adult therapeutic foster home shall ensure that the following documents are maintained at the adult therapeutic foster home:
1. The policies and procedures required in subsection (B),
2. Documentation of fire drills as required in R9-20-214(H),
3. Incident reports as required in R9-20-202, and
4. A copy of each client's current assessment and treatment plan.

D. A licensee or sponsor of an adult therapeutic foster home shall ensure that the Department is allowed immediate access to:
1. The adult therapeutic foster home,
2. A client living in the adult therapeutic foster home, and
3. A document required by this Article.

E. A licensee or sponsor of an adult therapeutic foster home shall assist a client with a regional behavioral health authority's grievance and appeal process to resolve a client's grievance.

R9-20-1502. Licensee Qualifications and Requirements

A. A licensee or sponsor of an adult therapeutic foster home shall:
1. Be at least 21 years old;
2. Have the behavioral health skills and knowledge necessary to meet the unique needs of a client living at the adult therapeutic foster home, including skills and knowledge in:
   a. Protecting the client rights listed in R9-20-203;
   b. Providing the behavioral health services that the adult therapeutic foster home is authorized to provide and the licensee is qualified to provide;
   c. Protecting and maintaining the confidentiality of client records and information;
   d. Recognizing and respecting cultural differences;
   e. Recognizing, preventing, or responding to a situation in which a client:
      i. May be a danger to self or a danger to others,
      ii. Behaves in an aggressive or destructive manner,
      iii. May be experiencing a crisis situation, or
      iv. May be experiencing a medical emergency;
   f. Reading and implementing a client's treatment plan; and
   g. Recognizing and responding to a fire, disaster, hazard, or medical emergency;
3. Have the behavioral health skills and knowledge required in subsection (A)(2) verified according to R9-20-204(F)(2) and documented according to R9-20-204(G)(1) through (4);
4. Have current documented successful completion of first-aid and CPR training specific to adults that included a demonstration of the licensee's ability to perform CPR;
5. Demonstrate freedom from infectious pulmonary tuberculosis, as required in R9-20-204(H)(2);
6. Complete at least 24 hours of training every twelve months in the topics listed in subsection (A)(2); and
7. Receive at least four hours a month of guidance in developing or improving skills and knowledge in providing behavioral health services from a behavioral health professional.

B. A licensee or sponsor shall ensure that a personnel record is maintained at the adult therapeutic foster home that contains documentation of the licensee's compliance with subsection (A).

R9-20-1503. Supervision

A. A licensee or sponsor of an adult therapeutic foster home shall ensure that a client receives the supervision necessary to:
1. Meet the requirements of this Article;
2. Ensure the health, safety, and welfare of the client at the adult therapeutic foster home and on an agency-sponsored activity off the premises; and
3. Meet the client's scheduled and unscheduled needs.

B. A licensee or sponsor of an adult therapeutic foster home shall ensure that a client receives:
1. General client supervision; and
2. Observation, assistance, or supervision in activities to maintain health, safety, personal care or hygiene, or independence in home making activities.

R9-20-1504. Admission

A licensee or sponsor of an adult therapeutic foster home shall ensure that, at the time of admission to the adult therapeutic foster home, a client:
1. Consents to treatment, according to R9-20-208(E),
2. Is provided the information required in R9-20-208(G), and
3. Demonstrates freedom from infectious pulmonary tuberculosis as required in R9-20-204(H)(2).

R9-20-1505. Assessment and Treatment Plan
A licensee or sponsor of an adult therapeutic foster home shall ensure that a client has an assessment and treatment plan that meets the requirements in R9-20-209.

R9-20-1506. Client Records
A licensee or sponsor of an adult therapeutic foster home shall ensure that a client record:
1. Is maintained according to R9-20-211(A);
2. Contains:
   a. The client's name and date of birth;
   b. The name and telephone number of:
      i. An individual to notify in case of an emergency;
      ii. The client's medical practitioner;
      iii. The individual who coordinates the client's behavioral health services or ancillary services; and
      iv. The client's parent, guardian, designated representative, custodian, or agent, if applicable;
   c. The date the client was admitted to the adult therapeutic foster home;
   d. The client's written consent to treatment, as required in R9-20-1504(1);
   e. Documentation of receipt of the information required in R9-20-1504(2);
   f. The client's assessment and any updates to the assessment;
   g. The client's treatment plan and any updates to the treatment plan;
   h. Documentation that the client is free from infectious pulmonary tuberculosis, as required in R9-20-1504(3); and
   i. The date of the client's discharge and the name of the individual or entity to whom the client was discharged, if applicable.

R9-20-1507. Environmental Standards
A. A licensee or sponsor of an adult therapeutic foster home shall ensure that the premises have:
1. A working telephone that allows a client to make a private telephone call;
2. At least one working toilet that flushes and one sink with running water;
3. At least one working bathtub or shower, with a slip resistant surface; and
4. An individual storage space, capable of being locked, for use by each client.

B. A licensee or sponsor of an adult therapeutic foster home shall ensure that a client's sleeping area is in a bedroom that:
1. Meets one of the following:
   a. Is a private bedroom that contains at least 60 square feet of floor space, not including the closet; or
   b. Is a shared bedroom that:
      i. Is shared by no more than four individuals;
      ii. Contains at least 60 square feet of floor space, not including a closet, for each individual occupying the bedroom; and
      iii. Provides at least three feet of space between beds;
2. Contains a door that opens into a corridor, common area, or the outside;
3. Is constructed and furnished to provide unimpeded access to the door;
4. Contains the following for each client:
   a. Individual storage space, such as a dresser or chest;
   b. A closet, wardrobe, or equivalent space for hanging clothes;
   c. A bed that:
      i. Consists of at least a mattress and frame;
      ii. Is in good repair, clean, and free of odors and stains; and
      iii. Is at least 36 inches wide and 72 inches long; and
   d. A pillow and linens that are clean, free of odors, and in good repair and that provide sufficient warmth to meet the needs of the client; and
5. Contains:
   a. Lighting sufficient for a client to read;
   b. To provide safe egress in an emergency, a working door to the outside or an openable window to the outside that is no higher than 20 feet above grade and that:
      i. Meets the fire safety requirements of the local jurisdiction;
      ii. Has no dimension less than 20 inches, has an area of at least 720 square inches, and has a window sill that is no more than 44 inches off the floor; or
      iii. Is large enough, accessible to a client, and within the capability of the client to egress in an emergency; and
   c. Adjustable window or door covers that provide client privacy.

C. A licensee or sponsor of an adult therapeutic foster home shall ensure that:

1. The supply of hot water is sufficient to meet:
   a. Each client's daily personal hygiene needs; and
   b. The laundry, cleaning, and sanitation requirements in this Article;
2. One of the following is available to ensure that client clothing can be cleaned:
   a. A working washing machine and dryer on the premises,
   b. An agency-provided process for cleaning clothing, or
   c. An agency-provided process for transporting a client to a building with washing machines and dryers that a client can use; and
3. Soiled linen and clothing stored by the licensee are in covered containers or closed plastic bags away from a ood preparation or storage area or a dining area.

D. A licensee or sponsor shall ensure that if a client's bedroom is capable of being locked from the inside, the licensee has a key that allows access to the bedroom at all times.

R9-20-1508. Food Services

A licensee or sponsor shall ensure that:
1. The meals and snacks served meet a client's nutritional needs based upon the client's age and health;
2. The meals and snacks served include a variety of foods from each food group in the Food Guide Pyramid, incorporated by reference in R9-20-301(C)(1);
3. At least a one-day supply of perishable food and at least a three-day supply of non-perishable food are maintained on the premises;
4. If a client needs a therapeutic diet, the requirements in R9-20-407(B)(10) are met; and
5. Food is obtained, prepared, served, and stored according to R9-20-407(C).

ARTICLE 16. ~~PARTIAL CARE SERVICES~~ REPEALED

R9-20-1601. ~~Partial Care Licensure Requirements~~ Repealed

~~**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.~~

R9-20-1602. ~~Basic Partial Care Services~~ Repealed

~~**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 case load 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.~~

R9-20-1603. ~~Intensive Partial Care Services~~ Repealed

~~**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.~~

ARTICLE 17. ~~DUI SERVICE AGENCIES~~ REPEALED

R9-20-1701. ~~Definitions~~ Repealed

~~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.~~

R9-20-1702. ~~DUI Service Agency Requirements~~ Repealed

~~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.~~

R9-20-1703. ~~Administration~~ <u>Repealed</u>

~~**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).~~

R9-20-1704. ~~Personnel~~ <u>Repealed</u>

~~**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.~~

R9-20-1705. ~~Staff Supervision~~ <u>Repealed</u>

~~**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.~~

R9-20-1706. ~~Staff Development and Training~~ Repealed

~~**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.~~

R9-20-1707. ~~DUI Screening Services~~ Repealed

~~**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.~~

R9-20-1708. ~~DUI Client Screening Records~~ Repealed

~~**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.~~

R9-20-1709. ~~DUI Education Services~~ Repealed

~~**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.~~

R9-20-1710. ~~DUI Client Education Records~~ Repealed

~~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.~~

R9-20-1711. ~~DUI Treatment Services~~ Repealed

~~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.~~

R9-20-1712. ~~DUI Client Treatment Records~~ Repealed

~~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.~~

R9-20-1713. ~~Physical Plant Requirements~~ Repealed

~~**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.~~

ARTICLE 18. ~~METHADONE OR METHADONE-LIKE TREATMENT AGENCIES~~ REPEALED

R9-20-1801. ~~Definitions~~ Repealed

~~**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.~~

R9-20-1802. ~~Methadone or Methadone-like Treatment Service Agency Requirements~~ Repealed

~~**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.~~

R9-20-1803. ~~Administration~~ Repealed

~~**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. Insure 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.~~

R9-20-1804. ~~Client Records for Methadone or Methadone-like Treatment Programs~~ Repealed

~~**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.~~

R9-20-1805. ~~Program Approval~~ Repealed

~~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.~~

R9-20-1806. ~~Admission and Discharge Criteria~~ Repealed

~~**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.~~

R9-20-1807. ~~Treatment Planning~~ Repealed

~~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.~~

R9-20-1808. ~~Drug Testing~~ Repealed

~~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.~~

R9-20-1809. ~~Emergency Initial Medication Administration Services~~ Repealed

~~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.~~

R9-20-1810. ~~Health Care Professionals~~ Repealed

~~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.~~

R9-20-1811. ~~Staff Authorized to Dispense or to Administer Narcotic Drugs~~ Repealed

~~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.~~

R9-20-1812. ~~Administration of Methadone~~ Repealed

~~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.~~

R9-20-1813. ~~Take-home Medication~~ Repealed

~~**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.~~

R9-20-1814. ~~Take-home Requirements~~ Repealed

~~**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.~~

R9-20-1815. ~~Short-term Detoxification Treatment Requirements~~ Repealed

~~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.~~

R9-20-1816. ~~Long-term Detoxification Treatment Requirements~~ Repealed

~~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.~~

R9-20-1817. ~~Hospital Use of Methadone for Detoxification Treatment~~ Repealed

~~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.~~

ARTICLE 19. ~~LEVEL II RURAL COUNTY DETOXIFICATION SERVICES PILOT PROGRAM~~ REPEALED

~~Part A. Pilot Program Requirements~~ Repealed

R9-20-A1901. ~~Definitions~~ Repealed

~~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.~~

R9-20-A1902. ~~Level II Rural County Detoxification Services Pilot Program~~ Repealed

~~**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.~~

~~Part B. Rural County Program Approval~~ Repealed

R9-20-B1901. ~~Approval Requirements~~ Repealed

~~**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 re-approval 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.~~

R9-20-B1902. ~~Management~~ Repealed

~~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.~~

R9-20-B1903. ~~Detoxification Services~~ Repealed

~~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.~~

R9-20-B1904. ~~Staffing Requirements~~ Repealed

~~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.~~

R9-20-B1905. ~~Program Description~~ Repealed

~~An agency shall provide a program description to each client upon admission. The program description shall describe the program's residence rules and services.~~

R9-20-B1906. ~~Facility Physical Plant Standards~~ Repealed

~~**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.~~

R9-20-B1907. ~~Recordkeeping~~ Repealed

~~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.~~

R9-20-B1908. ~~Fire and Safety~~ Repealed

~~**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.~~

R9-20-B1909. ~~Transfer to Another Classification~~ Repealed

~~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.~~

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

PREAMBLE

1. Sections Affected	Rulemaking Action
R9-22-101	Amend
R9-22-109	Amend
R9-22-112	Amend
R9-22-114	Amend
R9-22-115	Amend
R9-22-116	Repeal
R9-22-117	Amend
R9-22-201	Amend
R9-22-204	Amend
R9-22-210	Amend
R9-22-901	Repeal
R9-22-901	New Section
R9-22-902	Repeal
R9-22-902	New Section
R9-22-903	New Section
R9-22-904	New Section
R9-22-905	New Section
R9-22-906	New Section
R9-22-907	New Section
R9-22-908	New Section
R9-22-909	New Section
R9-22-1201	Amend
R9-22-1202	Amend
R9-22-1203	Amend
R9-22-1204	Amend
R9-22-1205	Amend
R9-22-1206	Amend
R9-22-1401	Repeal
R9-22-1401	New Section
R9-22-1402	Repeal
R9-22-1402	New Section
R9-22-1403	Repeal
R9-22-1403	New Section
R9-22-1404	Repeal
R9-22-1404	New Section
R9-22-1405	Repeal
R9-22-1405	New Section
R9-22-1406	Repeal
R9-22-1406	New Section
R9-22-1407	Repeal
R9-22-1407	New Section
R9-22-1408	Repeal
R9-22-1408	New Section
R9-22-1409	Repeal
R9-22-1409	New Section
R9-22-1410	Repeal
R9-22-1410	New Section
R9-22-1411	Repeal

R9-22-1411	New Section
R9-22-1412	Repeal
R9-22-1412	New Section
R9-22-1413	Repeal
R9-22-1413	New Section
R9-22-1414	Repeal
R9-22-1414	New Section
R9-22-1415	Repeal
R9-22-1415	New Section
R9-22-1416	Repeal
R9-22-1416	New Section
R9-22-1417	Repeal
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R9-22-1433	New Section
R9-22-1434	Repeal
R9-22-1435	Repeal
R9-22-1436	Repeal
R9-22-1501	Repeal
R9-22-1501	New Section
R9-22-1502	Repeal
R9-22-1502	New Section
R9-22-1503	Repeal
R9-22-1503	New Section
R9-22-1504	Repeal
R9-22-1504	New Section
R9-22-1505	Repeal
R9-22-1505	New Section
R9-22-1506	Repeal

R9-22-1507	Repeal
R9-22-1508	Repeal
R9-22-1601	Repeal
R9-22-1602	Repeal
R9-22-1603	Repeal
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R9-22-1606	Repeal
R9-22-1607	Repeal
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R9-22-1627	Repeal
R9-22-1628	Repeal
R9-22-1629	Repeal
R9-22-1630	Repeal
R9-22-1631	Repeal
R9-22-1633	Repeal
R9-22-1634	Repeal
R9-22-1636	Repeal
R9-22-1701	Amend
R9-22-1702	Amend
R9-22-1703	Amend
R9-22-1704	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 36-2903.01(F)

Implementing statute: Laws 2001, Chapter 344

3. The effective date of the rules:

October 1, 2001

4. A list of all previous notices appearing in the Register addressing the exempt rule:

Notice of Rulemaking Docket Opening: Volume 7 A.A.R. 2660, June 22, 2001

Notice of Public Meeting on Open Rulemaking Docket: Volume 7 A.A.R. 2960, July 6, 2001

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name:	Cheri Tomlinson, Federal and State Policy Administrator
Address:	AHCCCS, Office of Policy Analysis and Coordination 801 E. Jefferson, Mail Drop 4200 Phoenix, AZ 85034
Telephone:	(602) 417-4198

6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from the regular rulemaking procedures:

AHCCCS is amending the acute care rules to implement the new provisions of Proposition 204 in SB 1577 (Laws 2001, Ch. 344) including A.R.S. §§ 36-2901, 36-2901.03, 36-2901.04, 36-2903.01, 36-2903.03, 36-2904, 36-2905, 36-2905.01, 36-2905.02, 36-2905.03, 36-2905.05, 36-2906, 36-2907, 36-2908, and 36-2909. Proposition 204 and Laws 2001, Ch. 344 give AHCCCS the authority to streamline and simplify eligibility and expand coverage to all persons with income at or below 100 percent FPL. AHCCCS is exempt from the rulemaking requirements under Title 41, Ch. 6, of the Arizona Revised Statutes under Laws 2001, Ch. 344, § 113.

7. A reference to any study that the agency relied on in its evaluation of or justification for the rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

Not applicable

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

Not applicable

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

Not applicable

11. A summary of the principal comments and the agency response to them:

APPLICATION PROCESS

Comment: Denial for failure to cooperate and not providing verification contradicts federal law and policy.
Response: Removed "failure to cooperate" language from rules. Added language to make clear what is required of the applicant.

Comment: The rules should permit someone from the hospital to initiate an application on behalf of a hospitalized patient.
Response: Clarified that an application can be initiated in one of four ways:
1. The applicant;
2. The hospitalized applicant signs the Authorized Representative form;
3. The hospitalized person verbally authorizes a person in the presence of an eligibility interviewer; or
4. An incompetent/incapacitated form is signed by a licensed physician, physician assistant, nurse practitioner, or registered nurse and then someone acting responsibly can initiate the application.

Comment: The application process shall begin when the application is signed even if it is incomplete.
Response: Clarified that the date of application is the day a hospitalized applicant or authorized representative signs an application whether it is complete or incomplete.

Comment: The rules need to allow applications for a "John Doe".
Response: Clarified that DES will take the "John Doe" application and proceed to get the necessary information.

Comment: Clarify that DES has seven days to determine eligibility when DES receives the application.
Response: Clarified language requiring DES to complete an eligibility interview and determine eligibility for a hospitalized applicant within seven days of receiving a signed application.

Comment: DES should provide assistance and help the applicant complete the application.
Response. Clarified language that DES will help the applicant complete the application and ask all questions during the interview.

Comment: The rule language should allow physician discretion in obtaining a signature on an application when a person is in crisis or in pain.
Response: Current rule allows another person to initiate an application for a person in crisis or pain if the crisis or pain renders the person incompetent or incapacitated. Under rule, incapacity is verified by written documentation signed by a licensed physician, physician assistant, nurse practitioner, or a registered nurse under the direction of a licensed physician.

Comment: The application date should be retroactive back to the date of admission regardless of when the signature is obtained. A priority application system requires rapid and conclusive action by DES, many priority patients

need additional medical services after discharge and, unless these patients are eligible for AHCCCS when they leave, their services will be greatly hampered. The agency should be required to issue a decision based on reasonable inferences from the evidence. Hospitals should be granted an independent non-exclusive right to initiate, sign and pursue hospital based AHCCCS applications. The application need only contain the required information known at the time of submission. All applications should be approved or denied within 48 hours of the application date or the application is presumed approved. If the application is denied, it is not evidence to rebut the presumption.

All information contained on a signed and sworn application is presumed true unless controverted. DES can draw inferences of eligibility to facilitate making a determination of an incomplete application such as a person living in a homeless shelter or a person who is uninsured and unemployed.

Hospitals should approve under preponderance of evidence. If a worker fails to complete the interview or gather all information within a certain time periods but the information that is collected and verified suggests that the applicant is eligible then the worker should approve.

Response: By federal law, an application must be signed by the applicant or an authorized representative or, if incompetent or incapacitated, someone acting responsibly for the applicant. The application must be on a form prescribed by AHCCCS and the individual may choose someone to assist with the application. The individual's case record must have facts to support the eligibility decision unless the person has withdrawn the application, died or cannot be located. With the exception of the MED program, state law requires that the date of eligibility to be the first day of the month of application.

Comment: EMTALA prohibits interviews or question about the patients insurance because patients can be intimidated about the questions and leave the emergency room. For this reason hospitals need to be afforded an independent right to initiate, sign and pursue hospital-based applications.
Response: EMTALA requires that hospitals not delay medical screening or treatment in order to inquire about payment or insurance status. It does not prohibit asking the patient if he or she wants to fill out an application for Medicaid or filling out an application after the patient has been stabilized.

Comment: How quickly can DES get an interview completed for an expedited application?
Response: DES will attempt to interview all expedited applications at the time of initial application or as quickly as possible.

<u>ELIGIBILITY</u>
Comment: There should be a timeframe for DES to make a decision on the one-time MED eligibility date adjustment.
Response: Added a 30-day time-frame in rule for DES to determine the adjustment.

Comment: Reducing the spenddown period to three months will severely impact the emergency care system. Hospitalized patients present at the ER and frequently become eligible only through spenddown resulting from the expenses incurred as the result of the emergency, and therefore would not be captured under the DES enrollment process proposed under the regulations prior to the admission.
Response: State law and the 1115 waiver require a three-month period and an income level at 40 percent of the FPL.

Comment: Three month spend down is too short. The MED income spenddown threshold should be 100 percent FPL and not 40 percent.
Response: State law and the 1115 waiver require a three-month period and an income level at 40 percent of the FPL.

Comment: Hospitals had a problem with the 60 days that information could be provided to DES to change the effective date of eligibility for spenddown. Can this timeframe be changed?
Response: AHCCCS believes this is adequate time. Any bills go back to the month prior to application, therefore, the rule really allows almost 90 days.

<u>COMMUNICATION AND CONFIDENTIALITY</u>
Comment: Need to keep hospitals in the loop with the eligibility process by daily communication and coordination with hospital case management and social work staff.
Response: If the applicant releases a provider to receive information, this information will be shared. In the future, the application will be revised to permit an applicant to authorize the Administration and the Department to release information to the hospital if the applicant authorizes the release.

Comment: R9-22-512 restricts information. Hospitals want to have information regarding the eligibility status of

the person.
Response: The Administration will review this with CMS based on proposed HIPAA regulations.

GRIEVANCE AND HEARINGS
Comment: There should be a provision to appeal when a priority application determination takes longer than the seven days.
Response: Clarified language to allow for appeal of all timeframes in rule.

Comment: Hospitals should have the right to appeal a denial of eligibility.
Response: Hospitals could appeal a denial if they are the authorized representative.

Comment: A notice should inform a person that a denial/withdrawal means no AHCCCS health benefits coverage and that the applicant may have financial responsibility for the care not covered by AHCCCS.
Response: The universal application will inform the applicant that a denial/withdrawal means no AHCCCS benefits.

Comment: Current language states that eligibility is retroactive to the date of the Notice of Action and suggests that eligibility be retroactive to the application date in priority applications.
Response: Clarified language so that if the hearing decision is in favor of the appellant, eligibility is reinstated or retroactive to the first day of the month that the person was discontinued.

Comment: The applicant, applicant's authorized representative or a provider shall be allowed to file a grievance challenging a delay in a hospital based application two days following the application date.
Response: Rules do not set a limit. A grievance can be filed at anytime by an applicant or authorized representative.

Comment: The public wants two separate hearing processes for DES clients. Should AHCCCS do the Medicaid hearings instead of DES?
Response: The Administration shall enter into an IGA with DES to require the department to adopt rules, consistent with the rules adopted by the administration for a hearing process, that applicants or members may use for appeals of eligibility determinations or redeterminations.

A significant number, of Medicaid applicants also apply for cash assistance and/or food stamps at DES. The legislation requires DES to perform eligibility.

Comment: Delete the following language:
"At the hearing and on the record, the hearing officer finds that:
i. The sole issues involves application of law
ii. The Department properly applied the law, and
iii. The Department determined the correct level of assistance for the appellant."

Response: AHCCCS cannot delete the language since this is the federal standard. However, a notification requirement will be added to be more consistent with federal regulations.

SUB-EMERGENT
Comment: There are situations in which patients need "sub-emergency" care that may not require admission but requires follow-up. The recommendation was to add an exception to the 45-day timeframe for these types of situations.
Response: After October 1, 2001, AHCCCS will work on this issue with other parties.

NOTIFICATION
Comment: The requirement that a hospital notify the health plan or AHCCCS within 12 hours of an emergency hospitalization is inconsistent with federal EMTALA law because it is "prior authorization". ADHS only provides verification during normal week day hours and therefore the requirement for notification to the RBHA within 12 hours in this regulation should be eliminated because there is no way the hospital can obtain the information in the time frame.
Response: The Administration will review this issue when the federal regulations are final.

TIME-FRAMES
Comment: Requests that an application can be filed for a deceased applicant "or within 15 days of death, whichever is longer."
Response: If DES receives a signed application from an authorized person anytime during the month of death, coverage is extended to the first of the month. A provider can file an application for an incapacitated person.

Comment: Eligibility determinations should be completed within 30 days rather than 45; for Doses; 60 days rather

than 90.
Response: The time-frames in rule outline when the federal government requires a decision to be made no later than 45 days from the date of application. However, the Administration has a more expedited timeframe for pregnant women and inpatient applicants. The Administration will monitor the timelines of the Department on a regular basis.

MISCELLENEOUS
Comment: A "good cause" exemption should be added to the member's responsibility to cooperate with the Division of Child Support Enforcement (DCSE). The "good cause" exemption should also be added to the general "failure to cooperate" Section and if added the Department will explain "good cause" in the interview.
Response: Added the three step verification process in rule which allows client to provide written statement if documented or collateral verification is not available.

Comment: Request clarification for joint ownership, trusts, third party recoveries, vehicles, and lump sum payments.
Response: Clarified rule language.

Comment: Questioned why dependent children who are age 18 are not considered part of the family unit.
Response: Section 1931 of the SSA requires the state to count an 18 year old as part of the family unit.

Comment: It would generally be impossible to provide an 'itemized cost' before the a hospitalized patient receives non-covered services.
Response: Changed language from itemized to estimated costs.

Comment: Concerned that requiring a "health care practitioner" to have one year of full time behavioral health experience will impact the number of persons who could qualify to provide a behavioral health services.
Response: Consistent with the DHS behavioral health regulations that take effect October 1, 2001.

Comment: There should be a specific reference to estates managed by conservators. Restrictions issued by the courts should be sufficient proof of unavailability.
Response: Clarified language.

Comment: Suggests that "assistance of daily living" not have to be under a physician's prescription to be allowed as a deduction and suggest a better approach would be to tie the deduction to the physical status of the patient, in a manner similarly used on the PAS or exclude specific types of expenditures.
Response: Changed language to "documented in a plan of care".

Comment: If a person is later determined ineligible, neither AHCCCS nor DES should recoup or refund any amounts for care provided to an applicant who was determined eligible and whose enrollment was valid at the time payment was made. It is unclear whether AHCCCS will recoup payments from providers who have rendered services in reasonable reliance on a DES determination that the person is eligible for Medicaid.
Response: If a person was made eligible for Medicaid and a later quality control audit determines that this was an error, the individual will be terminated from the program prospectively.

Comment: Suggests that it is unclear which months are being used to determine monthly income for the family unit.
Response: Changed language to clarify the income calculation for a budget month.

Comment: Modify language that terminates the six-month enrollment guarantee when a member is determined eligible based on information that was erroneous.
Response: A person must be eligible for the six-month guarantee to be covered by federal dollars. Clarified language that a person must be "factually" ineligible to terminate the guaranteed enrollment period.

Comment: Statute requires a process to ensure that applications for the system can be accepted on a twenty-four hour basis, seven days a week. We agree that it would be more appropriate for this process to be outlined in AHCCCS policy rather than state rules. We request that the application process be developed with input from hospital and physician providers and other interested parties.
Response: The process for 24 hours, seven day a week process for level one hospitals will be in the IGA to allow flexibility to adjust as needed. AHCCCS is training interested hospitals on the eligibility process.

Comment: Would like to know the minimum frequency AHCCCS will sample DES eligibility activities and frequency of management review and suggest each quarter.
Response: The Administration samples on a monthly ongoing basis. Clarified language in rule.

Comment: Child support disregard should be raised from $50 to $72 for each additional child in the family.

Response: This is not a Medicaid issue and will have a budgetary impact.

Comment: Request a current market value deduction or no limit to the funeral amount deduction.
Response: This requirement only applies to the MED program and any change would have a budgetary impact.

Comment: Suggest the following change, "Cash contributions from other agencies or organizations so long as the contributions are ~~not~~ intended to cover the following…"
Response: Required by federal law to count.

Comment: Deductions for childcare should be indexed to the CPI for Phoenix.
Response: This is not a Medicaid issue.

Comment: AHCCCS should use the EMTALA definition of emergency services rather than the Medicaid definition for emergency services.
Response: AHCCCS must use the Medicaid cite at Section 1903(v) of the Social Security Act (42 USC 1396b(v)) because ARS 36-2903.03 defines emergency services by reference to 1903(v) which relates to eligibility for non-qualified aliens under Medicaid. In contrast, 42 USC 1395dd is part of Title XVIII of the Social Security Act (Medicare) and that statute addresses the requirement that, as a condition of participation in Medicare, hospitals with emergency departments must screen and provide stabilizing treatment to persons with emergency conditions (EMTALA).

Comment: Hospitals want financial sanctions and incentives in rules for DES to expedite applications.
Response: Financial sanctions will be in the IGA. This will allow the flexibility to adjust as needed.

Comment: "Incapacitated" and "incompetent" need to be defined. The suggestion of requiring a physician to attest to these conditions is "near impossible".
Response: Hospitals given the flexibility to define these terms.

Comment: Suggest that the rules should permit a hospital to initiate an application on behalf of a hospitalized patient "without resorting to undisclosed policy or IGA interpretations of the terms incompetent or incapacitated."
Response: Hospitals given the flexibility to define these terms.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
Not applicable

13. Incorporations by reference and their location in the rules:
None

14. Was this rule previously adopted as an emergency rule? If so, please indicate the Register citation:
No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

ARTICLE 1. DEFINITIONS

Section
R9-22-101. Location of Definitions
R9-22-109. Quality Control Related Definitions
R9-22-112. Behavioral Health Services Related Definitions
R9-22-114. ~~Title IV-A~~ AHCCCS Medical Coverage for Families and Individuals Related Definitions
R9-22-115. ~~SSI MAO~~ AHCCCS Medical Coverage for People Who Are Aged, Blind, or Disabled Related Definitions
R9-22-116. ~~State-only Eligibility Related Definitions~~ Repealed
R9-22-117. Enrollment Related Definitions

ARTICLE 2. SCOPE OF SERVICES

Section
R9-22-201. General Requirements
R9-22-204. Inpatient General Hospital Services
R9-22-210. Emergency Medical and Behavioral Health Services

ARTICLE 9. QUALITY CONTROL

Section
R9-22-901. ~~Quality Control Sample Review~~ General Information
R9-22-902. ~~Quality Control Case Analysis~~ Pre-Determination Quality Control (PDQC)
R9-22-903. ~~Repealed~~ Random Sample
R9-22-904. ~~Repealed~~ Targeted Sample
R9-22-905. ~~Repealed~~ Negative Case Action Sample
R9-22-906. ~~Repealed~~ Management Evaluation Review
R9-22-907. ~~Repealed~~ Challenge of Findings
R9-22-908. Corrective Action Plans
R9-22-909. Annual Assessment Period Report

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

Section
R9-22-1201. General Requirements
R9-22-1202. ADHS and ~~Health Plan~~ Contractor Responsibilities
R9-22-1203. Eligibility for Covered Services
R9-22-1204. General Service Requirements
R9-22-1205. Scope and Coverage of Behavioral Health Services
R9-22-1206. General Provisions and Standards for Service Providers

ARTICLE 14. ~~TITLE IV-A RELATED ELIGIBILITY~~ AHCCCS MEDICAL COVERAGE FOR FAMILIES AND INDIVIDUALS

Section
R9-22-1401. ~~Scope and Applicability~~ General Information
R9-22-1402. ~~Agency Responsible for Determining Eligibility~~ Ineligible Person
R9-22-1403. ~~Confidentiality~~ Agency Responsible for Determining Eligibility
R9-22-1404. ~~Case Record~~ Confidentiality
R9-22-1405. ~~Manuals~~ Application Process
R9-22-1406. ~~Eligibility Coverage Groups and an Eligible Applicant~~ Confidentiality Applicant and Member Responsibility
R9-22-1407. ~~Application~~ Withdrawal of Application
R9-22-1408. ~~Applicant and Recipient Responsibility~~ Confidential Eligibility Interview or Home Visit
R9-22-1409. ~~Death of an Applicant~~ Withdrawal from AHCCCS Medical Coverage
R9-22-1410. ~~Withdrawal of Application~~ Verification of Eligibility Information
R9-22-1411. ~~Initial Eligibility Interview~~ Time-frames, Approval, or Denial of the Application
R9-22-1412. ~~Withdrawal from the Medical Assistance Program~~ Review of Eligibility
R9-22-1413. ~~Verification of Eligibility Information~~ notice of Discontinuance Action
R9-22-1414. ~~Processing the Application - Approvals and Denials~~ Effective Date of Eligibility
R9-22-1415. ~~Review~~ Operation of Law
R9-22-1416. ~~Notice of Termination Action~~ Social Security Number
R9-22-1417. ~~Reinstatement of Medical Assistance~~ State Residency
R9-22-1418. ~~Dependent Child Living with Specified Relative~~ Citizenship and Immigrant Status
R9-22-1419. ~~Assistance Unit~~ Income Eligibility Criteria
R9-22-1420. ~~Deprivation~~ Eligibility for a Family
R9-22-1421. ~~Application for Other Benefits~~ Eligibility for a Person Not Eligible as a Family
R9-22-1422. ~~Assignment of Rights; Cooperation~~ Eligibility for a Newborn
R9-22-1423. ~~Social Security Number~~ Extended Medical Coverage for a Pregnant Woman
R9-22-1424. ~~State Residency~~ Family Planning Services Extension Program
R9-22-1425. ~~Citizenship and Alien Status~~ Young Adult Transitional Insurance
R9-22-1426. ~~Resources~~ Special Groups for Children
R9-22-1427. ~~Determining Resource Eligibility~~ Eligibility for a Person With Medical Bills Whose Income is Over 100 Percent FPL
R9-22-1428. ~~Income~~ MED Family Unit
R9-22-1429. ~~Earned Income Disregards~~ MED Income Eligibility Requirements
R9-22-1430. ~~Determining Income Eligibility~~ MED Resource Eligibility Requirements
R9-22-1431. ~~Effective Date of Eligibility~~ MED Effective Date of Eligibility
R9-22-1432. ~~Prior Quarter Eligibility~~ MED Eligibility Period
R9-22-1433. ~~Deemed Newborn Eligibility~~ Eligibility Appeals

R9-22-1434. ~~Extended Medical Assistance Coverage for a Pregnant Woman~~ Repealed
R9-22-1435. ~~Family Planning Services Extension Program~~ Repealed
R9-22-1436. ~~Eligibility Appeals~~ Repealed

ARTICLE 15. ~~SSI MAO ELIGIBILITY~~ AHCCCS MEDICAL COVERAGE FOR PEOPLE WHO ARE AGED, BLIND, OR DISABLED

Section
R9-22-1501. ~~SSI Medical Assistance Only (MAO) Coverage Groups~~ General Information
R9-22-1502. ~~Eligibility Determination Process~~ General Eligibility Criteria
R9-22-1503. ~~State Residency~~ Financial Eligibility Criteria
R9-22-1504. ~~Citizenship and Qualified Alien Status~~ Eligibility For Person Who Is Aged, Blind, Or Disabled
R9-22-1505. ~~Social Security Enumeration~~ Eligibility for Special Groups
R9-22-1506. ~~Resource Criteria for SSI MAO Eligibility~~ Repealed
R9-22-1507. ~~Income Criteria for Eligibility~~ Repealed
R9-22-1508. ~~Changes and Redeterminations~~ Repealed

ARTICLE 16. ~~STATE-ONLY ELIGIBILITY~~ REPEALED

Section
R9-22-1601. ~~Who May Apply for MI/MN Benefits~~ Repealed
R9-22-1602. ~~Application for MI/MN Benefits~~ Repealed
R9-22-1603. ~~Priority Applications for MI/MN Eligibility~~ Repealed
R9-22-1604. ~~MI/MN Applications for Applicants Facing a Loss of Categorically Eligible Status Due to Termination of SSI Benefits~~ Repealed
R9-22-1605. ~~Responsibilities of the Head-of-household for MI/ MN Eligibility~~ Repealed
R9-22-1606. ~~MI/MN Statement of Truth by the Head-of-household~~ Repealed
R9-22-1607. ~~Notice of Reapplication~~ Repealed
R9-22-1608. ~~County Responsibility for Completion of MI/MN Eligibility Determination~~ Repealed
R9-22-1609. ~~MI/MN Timeliness Requirements~~ Repealed
R9-22-1610. ~~Forwarding Applications to Obtain Categorical or Title XIX Eligibility~~ Repealed
R9-22-1611. ~~Eligibility for Medicare Beneficiaries~~ Repealed
R9-22-1612. ~~State-funded Coverage for Children~~ Repealed
R9-22-1613. ~~State Emergency Service Program (SESP)~~ Repealed
R9-22-1615. ~~Certification Periods~~ Repealed
R9-22-1616. ~~Denial or Discontinuance of MI/MN Eligibility~~ Repealed
R9-22-1617. ~~Notice of Action for Eligibility~~ Repealed
R9-22-1618. ~~Communication of Eligibility Determinations to the Administration~~ Repealed
R9-22-1619. ~~Rights Following Receipt of a Notice of Denial or Discontinuance of Coverage~~ Repealed
R9-22-1620. ~~Retroactive Coverage for MI/MN, ELIC, and SESP~~ Repealed
R9-22-1622. ~~Verification of Information for MI/MN Eligibility~~ Repealed
R9-22-1623. ~~Residence Requirements for MI/MN Eligibility~~ Repealed
R9-22-1624. ~~Citizenship and Alien Status Requirements for MI/ MN Eligibility~~ Repealed
R9-22-1625. ~~Household Composition for MI/MN Eligibility~~ Repealed
R9-22-1626. ~~Annual Income for MI/MN Eligibility~~ Repealed
R9-22-1627. ~~Resources for MI/MN Eligibility~~ Repealed
R9-22-1628. ~~Transfer of Resources for MI/MN Eligibility~~ Repealed
R9-22-1629. ~~Assignment of Rights~~ Repealed
R9-22-1630. ~~MI/MN Interim Changes~~ Repealed
R9-22-1631. ~~MI/MN Redeterminations~~ Repealed
R9-22-1633. ~~Case Record for MI/MN Applications~~ Repealed
R9-22-1634. ~~Eligibility Office Locations and Hours of Operation~~ Repealed
R9-22-1636. ~~Verification Review by the Director~~ Repealed

ARTICLE 17. ENROLLMENT

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

R9-22-101. Location of Definitions

A. Location of definitions. Definitions applicable to this Chapter are found in the following:

Definition	Section or Citation
~~"210"~~	~~R9-22-114~~
~~"1931"~~	~~R9-22-114~~
~~"1-time income"~~	~~R9-22-116~~
~~"1st-party liability"~~	~~R9-22-110~~
~~"3-month income period"~~	~~R9-22-116~~
~~"3rd-party"~~	~~R9-22-110~~
~~"3rd-party liability"~~	~~R9-22-110~~
"Accommodation"	R9-22-107
"Act"	R9-22-114
"Active case"	R9-22-109
"Acute mental health services"	R9-22-112
~~"Adequate notice"~~	~~R9-22-114~~
"ADHS"	R9-22-112
"Administration"	A.R.S. § 36-2901
"Administrative law judge"	R9-22-108
"Administrative review"	R9-22-108
"Adverse action"	R9-22-114
~~"AEC"~~	~~R9-22-117~~
"Affiliate corporate organization"	R9-22-106
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-115
"Aggregate"	R9-22-107
"AHCCCS"	R9-22-101
~~"AHCCCS-disqualified dependent"~~	~~R9-22-101~~
~~"AHCCCS-disqualified spouse"~~	~~R9-22-101~~
"AHCCCS inpatient hospital day or days of care"	R9-22-107
"Ambulance"	R9-22-102
"Ancillary department"	R9-22-107
"Annual assessment period"	R9-22-109
"Annual assessment period report"	R9-22-109
"Annual enrollment choice"	R9-22-117
"Appellant"	R9-22-114
"Applicant"	R9-22-101
"Application"	R9-22-101
"Assignment"	R9-22-101
~~"Assistance unit"~~	~~R9-22-114~~
"Authorized representative"	R9-22-114
"Auto-assignment algorithm"	R9-22-117
"Baby Arizona"	R9-22-114
"Behavior management services"	R9-22-112
"Behavioral health evaluation"	R9-22-112
~~"Behavioral health paraprofessional"~~	~~R9-22-112~~
"Behavioral health medical practitioner"	R9-22-112
"Behavioral health professional"	R9-22-112
"Behavioral health service"	R9-22-112
"Behavioral health technician"	R9-22-112
"Behavior management services"	R9-22-112
"BHS"	R9-22-114
"Billed charges"	R9-22-107
"Blind"	R9-22-115
"Board-eligible for psychiatry"	R9-22-112
~~"Bona fide funeral agreement"~~	~~R9-22-114~~
"Burial plot"	R9-22-114
"Capital costs"	R9-22-107
"Capped fee-for-service"	R9-22-101

Term	Reference
"Caretaker relative"	R9-22-114
"Case"	R9-22-109
~~"Case management services"~~	~~R9-22-112~~
"Case record"	R9-22-101 and R9-22-109
"Case review"	R9-22-109
"Cash assistance"	R9-22-114
"Categorically-eligible"	~~A.R.S. §§ 36-2901and 36-2934~~ R9-22-101
~~"Certification"~~	~~R9-22-109~~
~~"Certification error"~~	~~R9-22-109~~
~~"Certification period"~~	~~R9-22-115 and R9-22-116~~
"Certified psychiatric nurse practitioner"	R9-22-112
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-22-112
"CMDP"	R9-22-117
"CMS"	R9-22-101
"Complainant"	R9-22-108
"Continuous stay"	R9-22-101
"Contract"	R9-22-101
"Contractor"	~~R9-22-101~~ A.R.S. § 36-2901
~~"Contractor of record"~~	~~R9-22-101~~
"Copayment"	R9-22-107
"Corrective action plan"	R9-22-109
"Cost-to-charge ratio"	R9-22-107
~~"Countable income"~~	~~R9-22-116~~
~~"County eligibility department"~~	~~R9-22-109~~
~~"County eligibility staff"~~	~~R9-22-116~~
"Covered charges"	R9-22-107
"Covered services"	R9-22-102
"CPT"	R9-22-107
"CRS"	R9-22-114
~~"Date of determination"~~	~~R9-22-116~~
~~"Date of enrollment action"~~	~~R9-22-117~~
"Date of notice"	R9-22-108
"Day"	R9-22-101
"DCSE"	R9-22-114
~~"Deductible medical expense"~~	~~R9-22-116~~
~~"Deemed application date"~~	~~R9-22-116~~
"De novo hearing"	R9-22-112
"Dentures"	R9-22-102
"Department"	~~R9-22-114~~ A.R.S. § 36-2901
"Dependent child"	R9-22-114 ~~and R9-22-116~~
"DES"	R9-22-101
~~"Determination"~~	~~R9-22-116~~
"Diagnostic services"	R9-22-102
"Director"	R9-22-101
"Disabled"	R9-22-115
~~"Discontinuance"~~	~~R9-22-116~~
"Discussions"	R9-22-106
"Disenrollment"	R9-22-117
"District"	R9-22-109
~~"District Medical Consultant"~~	~~R9-22-114~~
"DME"	R9-22-102
"DRI inflation factor"	R9-22-107
"E.P.S.D.T. services"	R9-22-102
~~"EAC"~~	~~R9-22-101~~
~~"Earned income"~~	~~R9-22-116~~
~~"Educational income"~~	~~R9-22-116~~
~~"ELIC"~~	~~R9-22-101~~
"Eligible person"	A.R.S. § 36-2901

~~“Emancipated minor”~~	~~R9-22-116~~
“Emergency medical condition”	42 U.S.C. 1396b(v)
“Emergency medical services”	R9-22-102
“Encounter”	R9-22-107
“Enrollment”	R9-22-117
“Enumeration”	R9-22-101
“Equity”	R9-22-101
“Error”	R9-22-109
~~“Evaluation”~~	~~R9-22-112~~
~~“Expressly emancipated minor”~~	~~R9-22-116~~
“FAA”	R9-22-114
“Facility”	R9-22-101
“Factor”	R9-22-101
“FBR”	R9-22-101
“FESP”	R9-22-101
“Finding”	R9-22-109
“First-party liability”	R9-22-110
“Foster care maintenance payment”	41 U.S.C. 675(4)(A)
“FPL”	~~R9-22-114~~ A.R.S. § 1-215
“FQHC”	R9-22-101
~~“Fraudulent information”~~	~~R9-22-109~~
“Grievance”	R9-22-108
“GSA”	R9-22-101
~~“Guardian”~~	~~R9-22-116~~
~~“Head-of-household”~~	~~R9-22-116~~
“Health care practitioner”	R9-22-112
“Hearing”	R9-22-108
“Hearing aid”	R9-22-102
“Home health services”	R9-22-102
“Homebound”	R9-22-114
“Hospital”	R9-22-101
~~“Hospitalized”~~	~~R9-22-116~~
“ICU”	R9-22-107
“IHS”	R9-22-117
“IMD”	R9-22-112
“Income”	R9-22-114 ~~and R9-22-116~~
~~“Income-in-kind”~~	~~R9-22-116~~
~~“Indigent”~~	~~A.R.S. § 11-297~~
“Inmate of a public institution”	42 CFR 435.1009
~~“Inpatient psychiatric facilities for persons under age 21”~~	~~R9-22-112~~
“Interested party”	R9-22-106
~~“Interim change”~~	~~R9-22-116~~
~~“JTPA”~~	~~R9-22-114~~
“License” or “licensure”	R9-22-101
~~“Liquid assets”~~	~~R9-22-116~~
~~“Liquid resources”~~	~~R9-22-116~~
~~“Lump-sum income”~~	~~R9-22-116~~
“Mailing date”	R9-22-114
“Management evaluation review”	R9-22-109
“Medical education costs”	R9-22-107
“Medical expense deduction”	R9-22-114
“Medical record”	R9-22-101
“Medical review”	R9-22-107
“Medical services”	R9-22-101
“Medical supplies”	R9-22-102
“Medical support”	R9-22-114
“Medically necessary”	R9-22-101
“Medicare claim”	R9-22-107

“Medicare HMO”	R9-22-101
“Member”	R9-22-101
“Mental disorder”	R9-22-112
~~“MI/MN”~~	~~A.R.S. § 36-2901(4)(a) and (c)~~
~~“Minor parent”~~	~~R9-22-114~~
~~“Month of determination”~~	~~R9-22-116~~
“New hospital”	R9-22-107
“NF”	R9-22-101
“NICU”	R9-22-107
“Noncontracting provider”	~~A.R.S. § 36-2931~~ A.R.S. § 36-2901
“Nonliquid resources”	~~R9-22-116~~
“Nonparent caretaker relative”	R9-22-114
“Notice of Findings”	R9-22-109
“OAH”	R9-22-108
“Occupational therapy”	R9-22-102
“Offeror”	R9-22-106
“Operating costs”	R9-22-107
“Outlier”	R9-22-107
“Outpatient hospital service”	R9-22-107
“Ownership change”	R9-22-107
“Partial Care”	R9-22-112
“Party”	R9-22-108
“Peer group”	R9-22-107
“Performance measures”	R9-22-109
“Pharmaceutical service”	R9-22-102
“Physical therapy”	R9-22-102
“Physician”	R9-22-102
“Post-stabilization services”	42 CFR 438.114
“Practitioner”	R9-22-102
“Pre-enrollment process”	R9-22-114
“Preponderance of evidence”	R9-22-109
“Prescription”	R9-22-102
“Primary care provider”	R9-22-102
“Primary care provider services”	R9-22-102
“Prior authorization”	R9-22-102
“Private duty nursing services”	R9-22-102
“Proposal”	R9-22-106
“Prospective rates”	R9-22-107
“Prospective rate year”	R9-22-107
“Prudent layperson standard”	42 U.S.C. 1396u-2
“Psychiatrist”	R9-22-112
“Psychologist”	R9-22-112
“Psychosocial ~~rehabilitation”~~ rehabilitation services”	R9-22-112
~~“Public assistance”~~	~~R9-22-116~~
~~“Quality control case analysis”~~	~~R9-22-109~~
~~“Quality control sample review”~~	~~R9-22-109~~
“Quality management”	R9-22-105
“Radiology services”	R9-22-102
“Random sample”	R9-22-109
“RBHA”	R9-22-112
“Rebasing”	R9-22-107
~~“Recipient”~~	~~R9-22-114~~
~~“Redetermination”~~	~~R9-22-116~~
“Referral”	R9-22-101
“Rehabilitation services”	R9-22-102
“Reinsurance”	R9-22-107
“Resources”	R9-22-114 ~~and R9-22-116~~
“Respiratory therapy”	R9-22-102

“Respondent”	R9-22-108
“Responsible offeror”	R9-22-106
“Responsive offeror”	R9-22-106
“Review”	R9-22-114
“Review period”	R9-22-109
“RFP”	R9-22-106
“Scope of services”	R9-22-102
~~“Screening”~~	~~R9-22-112~~
“SDAD”	R9-22-107
“Section 1115 Waiver”	A.R.S. § 36-2901
~~“Separate property”~~	~~A.R.S. § 25-213~~
“Service location”	R9-22-101
“Service site”	R9-22-101
~~“SESP”~~	~~R9-22-101~~
“S.O.B.R.A.”	R9-22-101
“Specialist”	R9-22-102
“Specified relative”	R9-22-114 ~~and R9-22-116~~
“Speech therapy”	R9-22-102
“Spendthrift restriction”	R9-22-114
“Spouse”	R9-22-101
“SSA”	P.L. 103-296, Title I
“SSI”	R9-22-101
“SSN”	R9-22-101
~~“State alien”~~	~~R9-22-101~~
“Sterilization”	R9-22-102
“Subcontract”	R9-22-101
~~“Substance abuse”~~	~~R9-22-112~~
“Summary report”	R9-22-109
“SVES”	R9-22-114
“Third-party”	R9-22-110
“Third-party liability”	R9-22-110
“Tier”	R9-22-107
“Tiered per diem”	R9-22-107
~~“Title IV-A”~~	~~R9-22-114~~
“Title IV-D”	R9-22-114
“Title IV-E”	R9-22-114
“Title XIX”	42 U.S.C. 1396
“Title XXI”	~~42 U.S.C. 1397jj~~ 42 U.S.C. 1397aa
~~“TMA”~~	~~R9-22-114~~
“Tolerance level”	R9-22-109
“Total inpatient hospital days”	R9-22-107
~~“Treatment”~~	~~R9-22-112~~
~~“Unearned income”~~	~~R9-22-116~~
“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:

“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.

~~“AHCCCS-disqualified dependent” means a dependent child of an AHCCCS-disqualified spouse who resides in the same household of an AHCCCS-disqualified spouse.~~

~~“AHCCCS-disqualified spouse” means the spouse of an MI/MN applicant, who is ineligible for MI/MN benefits because the value of that spouse’s separate property, when combined with the value of other resources owned by household members, exceeds the allowable resource limit.~~

“Applicant” means a person who submits or whose authorized representative submits, a written, signed, and dated application for AHCCCS benefits ~~that has not been approved or denied~~.

“Application” means an official request for ~~medical assistance~~ AHCCCS medical coverage made under this Chapter.

"Assignment" means enrollment of a member with a contractor by the Administration.

"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 service and equipment provided to a member. A ~~payments~~ payment is made in accordance with an upper, or capped, limit established by the Director.

"Case record" means the file and all documents in the file that are used to establish eligibility.

"Categorically-eligible" means a person who is eligible ~~as defined by~~ under A.R.S. §§ 36-2901(i), (ii), or (iii) and 36-2934.

"CMS" means the Centers for Medicare and Medicaid Services.

"Continuous stay" means the period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

"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.

~~"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.~~

~~"Contractor of record" means an organization or an entity in which a person is enrolled for the provision of AHCCCS services.~~

"Day" means a calendar day unless otherwise specified in the text.

"DES" means the Department of Economic Security.

"Director" means the Director of the Administration or the Director's designee.

~~"DES" means the Department of Economic Security.~~

~~"EAC" means eligible assistance children defined by A.R.S. § 36-2905.03.~~

~~"ELIC" means eligible low-income children defined by A.R.S. § 36-2905.03~~.

"Eligible person" means the person defined in A.R.S. § 36-2901.

"Enumeration" means the assignment of a specific ~~9-digit~~ nine-digit identification number to a person by the Social Security Administration.

"Equity" means the county assessor full cash or market value of a resource minus valid liens, encumbrances, or both.

"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.

"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.

"FBR" means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

"FESP" means federal emergency services program that is designed to provide emergency medical services covered under 42 U.S.C. 1396b(v), to treat an emergency medical condition for a categorically-eligible member who is determined eligible under A.R.S. § 36-2903.03.

"FQHC" means federally qualified health center.

"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.

"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.

~~"Indigent" means meeting eligibility criteria under A.R.S. § 11-297.~~

"Inmate of a public institution" means a person defined by 42 CFR 435.1009.

"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.

"Medical record" means all documents that relate to medical and behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that are kept at the site of the provider.

"Medical services" means health care services provided to a member 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.

"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:

~~Prevent~~ prevent disease, disability, and other adverse health conditions or their progression; or

~~Prolong~~ prolong life.

"Medicare HMO" means a health maintenance organization that has a current contract with ~~The Health Care Financing Administration (HCFA)~~ Centers for Medicare and Medicaid for participation in the Medicare program under 42 CFR 417(L).

"Member" is defined in A.R.S. § 36-2901.

~~"MI/MN" means medically indigent and medically needy defined in A.R.S. § 36-2901(4)(a) and (c).~~

"NF" means a nursing facility defined in 42 U.S.C. 1396r(a).

"Noncontracting provider" ~~means the provider~~ is defined in ~~A.R.S. § 36-2931~~ A.R.S. § 36-2901.

"Referral" means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

~~"Separate property" means property defined in A.R.S. § 25-213.~~

"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.

"Service site" means a location designated by a contractor of record as the location at which a member is to receive health care services.

~~"SESP" means state emergency services program that is 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.~~

"S.O.B.R.A." means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, ~~42 U.S.C. 1396a(a)(10)(A)(ii)(IX), July 1, 1988.~~ 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).

"Spouse" means the husband or wife who has entered into a contract of marriage, recognized as valid by Arizona.

"SSA" means Social Security Administration ~~defined in~~ under P.L. 103-296, Title I.

"SSI" means Supplemental Security Income under Title XVI of the Social Security Act, as amended.

"SSN" means social security number.

~~"State alien" means an nonqualified alien under A.R.S. § 36-2903.03 who:~~

~~Was residing in the United States under color of law on or before August 21, 1996;~~

~~Was receiving AHCCCS services under SSI eligibility criteria; and~~

~~Would be eligible for coverage under 9 A.A.C. 22, Article 15 except for United States citizenship or legal alienage requirements.~~

"Subcontract" means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member;

A marketing organization; or

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.

R9-22-109. Quality Control Related Definitions

~~In addition to definitions contained in A.R.S. § 36-2901, words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:~~

1. ~~"Certification" means approval of eligibility under Article 16.~~
2. ~~"Certification error" means an error defined in A.R.S. § 36-2905.01(I), R9-22-901(A), and R9-22-902(A).~~
3. ~~"Corrective action plan" means a plan developed by a county eligibility department to reduce the county eligibility department's error rate calculated under A.R.S. § 36-2905.01(A).~~
4. ~~"County eligibility department" means an entity within a county administration that is responsible for determining eligibility under Article 16.~~
5. ~~"Fraudulent information" means information provided or withheld intentionally for the purpose of obtaining benefits that a person would not otherwise be entitled to receive.~~
6. ~~"Quality control case analysis" means the Administration's evaluation of individual case records, under A.R.S. § 36-2905.02, of a county eligibility department's eligibility determinations.~~
7. ~~"Quality control sample review" means the Administration's evaluation of a statistically valid sample of case records, under A.R.S. § 36-2905.01, of a county eligibility department's eligibility determinations.~~

"Active case" means an individual or family case determined eligible for AHCCCS medical coverage.

"Annual assessment period" means the 12 month period, October 1 through September 30, and includes two six month sample periods (October through March and April through September).

"Annual assessment period report" means the Administration's report containing the annual error rates for the Random Sample, Target Sample, and Negative Case Action Sample.

"Case" means an individual or family determined eligible or ineligible for AHCCCS medical coverage.

"Case record" means an individual or family file retained by the Department which contains all pertinent eligibility information, including electronically stored data.

"Case review" means the Administration's evaluation of an individual's or family's circumstances and case record in a review month to determine if an individual or family is eligible based on the actual circumstances verified for the action taken in a review month for AHCCCS.

"Corrective action plan" means a effective plan developed by the Department to reduce the Department's error rate when an error rate exceeds a tolerance level.

"District" means the Department's management unit based on geographical location that administers the eligibility programs.

"Error" means a review finding in which one or more members is found to be factually ineligible, approved for a program with more services under Title XIX than an applicant or member is entitled to, or discontinued or denied when a member is factually eligible in a review month. An error may include misclassification resulting in additional expenses or liability to the Administration or loss of AHCCCS medical coverage for the applicant or member.

"Finding" means a result based on the Administration's review.

"Management evaluation review" means the process by which the Administration determines whether the Department meets specific performance measures.

"Notice of Findings" means a report provided to the Department by the Administration when a review is completed.

"Performance measures" means the methods by which the Administration determines the extent to which the Department meets the pre-determined standards and goals.

"Preponderance of evidence" means the greater weight of evidence.

"Random sample" means a representative population with each case having an equal chance of being chosen, hav-

ing no specific pattern, purpose, organization, or structure other than as defined by case characteristic.

"Review period" means the April through September and October through March time periods that the Administration selects and completes a review of case records.

"Summary report" means the Administration's report issued at the end of each six month review period summarizing all review findings including eligibility errors, technical errors, administrative deficiencies, and corrective action requirements.

"Tolerance level" means the percentage of errors which the Administration accepts.

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:

~~1.~~ "ADHS" means the Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona residents.

~~2.~~ "Behavior management services" ~~specified in 9 A.A.C. 20.~~ means those services that assist the member in carrying out daily living tasks and other activities essential for living in the community.

"Behavioral health evaluation" means the assessment of a member's medical, psychological, psychiatric, or social condition to determine if a behavioral health disorder exists and, if so, to establish a treatment plan for all medically necessary services.

~~3.~~ ~~"Behavioral health paraprofessional" defined in 9 A.A.C. 20, Article 1.~~

"Behavioral health medical practitioner" means a health care practitioner with at least one year of full-time behavioral health work experience.

~~4.~~ "Behavioral health professional" defined in ~~9 A.A.C. 20, Article 1.~~ 9 A.A.C. 20.

~~5.~~ "Behavioral health ~~services" defined in~~ ~~9 A.A.C. 20, Article 1.~~ service" means those services provided for the evaluation and diagnosis of a mental health or substance abuse condition, and the planned care, treatment, and rehabilitation of the member.

~~6.~~ "Behavioral health technician" defined in ~~9 A.A.C. 20, Article 1.~~ 9 A.A.C. 20.

~~7.~~ "Board-eligible for psychiatry" means completion of an accredited psychiatry residency program approved by the American College of Graduate Medical Education, or the American Osteopathic Association. Documentation of completion of a residency program includes a certificate of residency training including exact dates of residency, or a letter of verification of residency training from the training director including the exact dates of training period.

~~8.~~ ~~"Case management services" means supportive services and activities that enhance treatment, compliance, and effectiveness of treatment. This definition is applicable for purposes of Article 12 only.~~

~~9.~~ "Certified psychiatric nurse practitioner" ~~as specified in~~ under A.R.S. § 32-1601 and certified under the American Nursing Association's Statement and Standards for Psychiatric-Mental Health Clinical Nursing Practice under A.A.C. R4-19-505.

~~10.~~ "Clinical supervision" ~~specified in 9 A.A.C. 20~~ means a review of skills and knowledge and guidance in improving or developing skills and knowledge provided by a Clinical Supervisor under 9 A.A.C. 20, Article 2.

~~11.~~ "De novo hearing" defined in ~~42 CFR 431.202.~~ 42 CFR 431.201.

~~12.~~ ~~"Evaluation" means the initial assessment of a member's medical, psychological, psychiatric, or social condition to determine if a behavioral health disorder exists and, if so, to establish a treatment plan for all medically necessary services.~~

"Health care practitioner" means a:

Physician;
Physician assistant;
Nurse practitioner; or
Other individual licensed and authorized by law to use and prescribe medication and devices, as defined in A.R.S. 32-1901.

~~13.~~ "IMD" means an Institution for Mental Diseases as described in 42 CFR 435.1009 and licensed by ADHS.

~~14.~~ ~~"Inpatient psychiatric facilities" for individuals under age 21" means a licensed hospital or a psychiatric hospital or a Residential Treatment Center (RTC) licensed as a Level 1 behavioral health facility by ADHS and accredited by an AHCCCS-approved accrediting body as specified in contract and authorized by federal law or regulations. These facilities provide room and board and treatment for behavioral health disorder of an individual who is under 21 years of age.~~

~~15.~~ "Mental disorder" defined in A.R.S. § 36-501.

~~16.~~ "Partial Care" means~~:~~

a day program of services provided to individual members or groups designed to improve the ability of a person to function in the community.

~~a. "Basic partial care" specified in 9 A.A.C. 20.~~
~~b. "Intensive partial care services" specified in 9 A.A.C. 20.~~

~~17.~~ "Psychiatrist" ~~specified in~~ under A.R.S. §§ 32-1401 or 32-1800 and 36-501.
~~18.~~ "Psychologist" ~~specified in~~ under A.R.S. §§ 32-2061 and 36-501.
~~19.~~ ~~"Psychosocial rehabilitation" specified in 9 A.A.C. 20.~~ "Psychosocial rehabilitation services" mean those services that include the provision of education, coaching, training, and demonstration to remediate residual or prevent anticipated functional deficits and may include services that may assist a member to secure and maintain employment. Psychosocial rehabilitation services may include:
  Living skills training,
  Cognitive rehabilitation,
  Health promotion,
  Supported employment, and
  Other services which increase social and communication skills in order to maximize a member's ability to participate in the community and function independently.

~~20.~~ "RBHA" means the Regional Behavioral Health Authority defined in ~~9 A.A.C. 21, Article 1.~~ A.R.S. § 36-3401.
~~21. "Screening" means a face-to-face interaction with a member to determine the need for behavioral health services and the referral of the member for further evaluation, diagnosis, or care and treatment.~~
~~23. "Substance abuse" defined in 9 A.A.C. 20, Article 1.~~
~~24. "Treatment" defined in 9 A.A.C. 20, Article 1.~~

R9-22-114. ~~Title IV-A~~ AHCCCS Medical Coverage for Families and Individuals 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:

~~"210" means 42 CFR 435.210.~~

~~"1931" means Section 1931 of the Social Security Act.~~

"Act" means the Social Security Act.

~~"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.~~

"Adverse action" means an action taken by the Department to deny, discontinue, or reduce medical assistance.

"Appellant" means an applicant or ~~recipient of~~ ~~medical assistance~~ member who is appealing an adverse action by the Department.

~~"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.~~

"Authorized representative" means a person who is authorized ~~by the applicant, recipient, or legally responsible person to act on behalf of the applicant~~ to apply or act on behalf of another person.

"Baby Arizona" means the public or private partnership program that provides a pregnant woman an opportunity to apply for ~~medical assistance~~ AHCCCS medical coverage at a Baby Arizona provider's office through a streamlined eligibility process.

"BHS" means Behavioral Health Services, Arizona Department of Health Services.

~~"Bona fide funeral agreement" means a prepaid plan that specifically covers only funeral-related expenses as evidenced by a written contract.~~

"Burial plot" means a space reserved in a cemetery, crypt, vault, or mausoleum for the remains of a deceased person.

"Caretaker relative" means a parent or other specified 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.

"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.

"CRS" means ADHS Children's Rehabilitation Services.

"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.

~~"Department" means the Arizona Department of Economic Security.~~

"Dependent child" means a child defined in A.R.S. § 46-101.

~~"District Medical Consultant" means a licensed physician whom the Department employs to review medical records for the purpose of determining physical or mental incapacity.~~

"FAA" means the Family Assistance Administration, the administration within the Department's Division of Benefits and Medical Eligibility with responsibility for providing cash and food stamp assistance to a member and for determining eligibility for ~~medical assistance~~ AHCCCS medical coverage.

"Foster care maintenance payment" means a monetary amount defined in 42 U.S.C. 675(4)(A).

~~"FPL" means the federal poverty level guidelines published annually by the United States Department of Health and Human Services.~~

"Homebound" means a person who is confined to home because of physical or mental incapacity.

"Income" means combined earned and unearned income.

~~"JTPA" means the Job Training Partnership Act program authorized by 29 U.S.C. 1501 et seq. that prepares youth and unskilled adults for entry into the labor force and provides special job training.~~

"Mailing date", when used in reference to a document sent ~~1st~~ first class, postage prepaid, through the United States mail, means the date:

Shown on the postmark;
Shown on the postage meter mark of the envelope, if no postmark; or
Entered on the document as the date of its completion, if no legible postmark or postage meter ~~mark.~~ mark or if the mark is illegible.

"Medical expense deduction" means the cost of:

A medical service or supply that would be covered if provided to an AHCCCS member of any age under 9 A.A.C. 22, Articles 2 and 12;
A medical service or supply that would be covered if provided to an ALTCS member under 9 A.A.C. 28, Articles 2 and 11;
Other necessary medical services provided by a licensed practitioner or physician;
Assistance with daily living provided the assistance is documented in an individual plan of care except when provided by the spouse of a applicant or the parent of a minor child;
Medical services provided 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;
Purchasing and maintaining animal guide or service animal for the assistance of the member of the MED family unit; or
Health insurance premiums, deductibles, and coinsurance, if the insured is a member of the MED family unit.

"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.

~~"Minor parent" means a person meeting the age requirement of R9-22-1401 who is also a parent.~~

"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.

"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.

~~"Recipient" means a person who is approved for and receiving medical assistance under 9 A.A.C. 22, Article 14.~~

"Resources" means real and personal property, including liquid assets.

"Review" means a review of all factors affecting an ~~assistance~~ unit's a family's eligibility.

"Specified relative" ~~means a person defined in R9-22-1418.~~ natural or adoptive parent or a stepparent and any other nonparent relative related by blood or adoption including a spouse of these persons even if death or divorce terminates the marriage. Specified relative may include:

Grandmother;

Grandfather;
Brother;
Sister;
Uncle;
Aunt;
First cousin;
Nephew;
Niece;
Persons of preceding generations as denoted by prefixes grand or great, or to the fifth degree grandparent; and
First cousins once removed.

"Spendthrift restriction" means a legal restriction on the use of a resource that prevents a payee or beneficiary from alienating the resource.

"SVES" means the State Verification and Exchange System, 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.

~~"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 in place in the state's Title IV-A State Plan as of July 1996.~~

"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.

"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.

~~"TMA" means Transitional Medical Assistance.~~

R9-22-115. ~~SSI MAO~~ AHCCCS Medical Coverage for People Who Are Aged, Blind, or Disabled 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).

R9-22-116. ~~State-Only Eligibility Related Definitions~~ Repealed

~~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-time income" means income that a person may receive only once. Examples are:~~

~~The total of gifts received during the 3-month income period for a birthday, wedding, anniversary, graduation, religious event, or birth;~~
~~The total of single payment death benefits; or~~
~~The total of single payment insurance or a legal settlement resulting from 1 accident.~~
~~"3-month income period" means the 91 or 92 days immediately preceding the application date. The 3-month income period is 92 days if:~~
~~A household member regularly receives a monthly or 2-times-a-month payment, and~~
~~The household member received the 3rd of 3 monthly payments on the 92nd day preceding the application date, or~~
~~The household member received the 6th of 6 2-times-a-month payments on the 92nd day preceding the application date.~~

~~"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.~~

~~"Countable income" means gross income, less amounts that are disregarded under R9-22-1626 and amounts that are deducted under R9-22-1626.~~

~~"County eligibility staff" means a county employee designated to conduct eligibility interviews and determinations for AHCCCS or conduct related business.~~

~~"Date of determination" means the date on which a decision of an applicant's eligibility or ineligibility as MI/ MN, ELIC, or SESP is communicated by the county to the applicant by a Notice of Action and, for a member, to the Administration as specified in R9-22-1618.~~

~~"Deductible medical expense" means the cost of:~~

~~A medically necessary service or supply that would be covered if provided to an AHCCCS member of any age under 9 A.A.C. 22, Articles 2 and 12;~~
~~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;~~
~~Other medically necessary services that are provided by a licensed practitioner or physician;~~
~~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;~~
~~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;~~
~~Purchasing and maintaining a dog guide or service dog for the assistance of the applicant or member; or~~
~~Health insurance premiums if the insured is a household member.~~

~~"Deemed application date" means the 30th day following either the original application date or a previously deemed application date, whichever is later.~~

~~"Dependent child" means an unborn child, an unemancipated minor, or an 18-year-old, if all of the following 3 conditions exist:~~

~~The 18-year-old is a full-time student in a secondary school, or in a vocational, technical, or trade school that grant credits toward secondary school graduation;~~
~~The 18-year-old is reasonably expected to graduate before reaching age 19; and~~
~~The 18-year-old resides with 1 or both parents or a specified relative.~~

~~"Determination" means the process by which an applicant is approved or denied for coverage as an MI/MN, ELIC, or SESP applicant.~~

~~"Discontinuance" means an action taken by county eligibility staff or the Administration to terminate a member's eligibility under MI/MN, ELIC, or SESP.~~

~~"Earned income" means money or its equivalent received by a household member in exchange for:~~
~~Labor;~~
~~Professional service or entrepreneurship, including income from the rental of real or personal property;~~
~~Vacation pay;~~
~~Sick pay;~~
~~Tips; and~~

~~Gratuities.~~

~~"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.~~

~~"Emancipated minor" means a minor who is married or divorced, in military service, or the subject of a court order declaring the minor emancipated.~~

~~"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~~
~~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.~~

~~"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.~~

~~"Head-of-household" means a member of the household under R9-22-1624 who assumes the responsibility for providing AHCCCS eligibility information for all household members.~~

~~"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.~~

~~"Income" means money or other liquid resource at the moment it:~~

~~Is received or deemed received by a person under R9-22-1626;~~
~~Becomes available for the person's legal unrestricted use;~~

~~Is drawn by a person from a source not owned by the person for the person's separate use, benefit, or disposal; or~~

~~Is due to the 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.~~

~~"Income-in-kind" means any noncash item or service received that is not deducted from other income to which the recipient of that noncash item or service is entitled.~~

~~"Interim change" means either a change occurring after the application date and before the eligibility decision or a change occurring during the certification period.~~

~~"Liquid assets" means all property and resources readily convertible to cash.~~

~~"Liquid resources" means all property and resources readily convertible to cash.~~

~~"Lump-sum income" means income received in a single payment instead of regularly occurring installments over a period of time.~~

~~"Month of determination" means the calendar month the date of determination occurs.~~

~~"Nonliquid resources" means all resources that are not readily convertible to cash.~~

~~"Public assistance" means benefits provided to a person, either directly or indirectly by a city, county, state, federal, or governmental agency, based on financial need.~~

~~"Redetermination" means the process by which a member 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.~~

~~"Resources" means property of any kind, real or personal, that can be used to obtain food, clothing, shelter, medical care, or money.~~

~~"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 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 person.~~

~~"Unearned income" means all income defined in this Section except income that is defined as earned income.~~

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.~~ Program.
~~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.~~ Service.

ARTICLE 2. SCOPE OF SERVICES

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 noncategorically eligible person for 48 hours prior to enrollment in the system;~~

~~5.~~4. Experimental services as determined by the director, or services provided primarily for the purpose of research, shall not be covered;

~~6.~~5. AHCCCS services shall be limited to those services that are not covered for a member or eligible person who is a Medicare beneficiary;

~~7.~~6. Services or items, if furnished gratuitously, are not covered and payment shall be denied;

~~8.~~7. Personal care items are not covered and payment shall be denied;

~~9.~~8. ~~Medical or behavioral health~~ AHCCCS covered services shall not be covered if provided to:
   a. An inmate of a ~~prison;~~ public institution;
   b. A person who is in residence at an institution for the treatment of tuberculosis; or
   c. A person age 21 through 64 who is in an institution for the treatment of mental ~~disorders~~ diseases, unless provided ~~according to~~ under 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,~~ member 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~~ member'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 estimated 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~~ a member may receive services, other than emergency services, from service providers outside ~~the eligible person's~~ a member'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~~ under 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~~ under Title XIX of the Social Security Act, as amended.

R9-22-204. Inpatient General Hospital Services

A. Inpatient services provided in a general hospital shall be provided by contractors, fee-for-service providers, or noncontracting providers and shall include:
1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
   a. Maternity care, including labor, delivery, and recovery room, birthing center, and newborn nursery;
   b. Neonatal intensive care unit (NICU);
   c. Intensive care unit (ICU);
   d. Surgery, including surgery room and recovery room;
   e. Nursery and related services;
   f. Routine care; and
   g. ~~Behavioral health care:~~
      ~~i. Behavioral health emergency crisis stabilization services shall be provided for up to 3 days per acute episode and no more than 12 days per AHCCCS contract year for each member unless services are provided under 9 A.A.C. 22, Article 12.~~
      ~~ii. Emergency behavioral health services for a member eligible under A.R.S. § 36-2901(4)(b) shall be provided as specified in 9 A.A.C. 22, Article 12.~~
      ~~iii. For purposes of this Section, the AHCCCS contract year shall be October 1 through September 30.~~
   Emergency behavioral health services for a member eligible under A.R.S. §§ 36-2901(6)(a), 36-2901.01, and 36-2901.04 provided under 9 A.A.C. 22, Article 12.
2. Ancillary services as specified by the Director and included in contract:
   a. Laboratory services;
   b. Radiological and medical imaging services;
   c. Anesthesiology services;
   d. Rehabilitation services;
   e. Pharmaceutical services and prescribed drugs;
   f. Respiratory therapy;
   g. Blood and blood derivatives; and
   h. Central supply items, appliances, and equipment not ordinarily furnished to all patients and customarily reimbursed as ancillary 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 a member shall be incorporated into the rate paid for the level of care as ~~specified in~~ under subsection (A)(1).
2. Prior authorization shall be obtained from the Administration for the following inpatient hospital services provided to a member:
   a. Nonemergency and elective admission, including psychiatric hospitalization;
   b. Elective surgery, with the exception of voluntary sterilization procedures, shall be authorized before the surgery;
   c. An emergency hospitalization that exceeds ~~3~~ three days or an intensive care unit admission that exceeds ~~1~~one day;
   d. Hospitalization beyond the number of days initially authorized shall be covered only if determined medically necessary through AHCCCS Administration concurrent team review; and
   e. Services or items furnished to cosmetically reconstruct appearance after the onset of trauma or serious injury before service delivery.

R9-22-210. Emergency Medical and Behavioral Health Services

A. Provision of and payment for emergency services. An emergency medical or behavioral health 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 shall be provided ~~as specified in~~ ~~42 U.S.C. 1396u-2, 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.~~ under 42 U.S.C. 1396u-2.

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, emergency medical, or behavioral health services shall be available 24 hours per day, seven 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. ~~Evaluation. Evaluation~~ Behavioral health evaluation. A behavioral health evaluation provided by a psychiatrist or a psychologist ~~may~~ shall be covered as an emergency service as ~~specified in~~ under this Section ~~R9-22-210~~ if required to evaluate or stabilize an acute episode of mental disorder or substance abuse. ~~Evaluation for Title XIX members shall be covered as specified in R9-22-1205.~~

E. Prior authorization. An emergency service does not require prior authorization; however, a provider shall comply with the following notification requirements:

1. A ~~provider, a nonprovider,~~ provider 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:
   a. Notify a member's contractor before initiation of treatment;
   b. 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,~~ provider and a noncontracting provider shall request authorization from a contractor for post-stabilization services ~~as specified in 42 U.S.C. 1396u-2, August 5, 1997, incorporated by reference in subsection (A).~~ under 42 U.S.C. 1396u-2.

ARTICLE 9. QUALITY CONTROL

R9-22-901. ~~Quality Control Sample Review~~ General Information

~~**A.** Certification errors. The Administration shall include the following as certification errors for a quality control sample review conducted under A.R.S. § 36-2905.01:~~

~~1. A county eligibility department's failure to provide a case record, defined in R9-22-1633, that the Administration selects for review under A.R.S. § 36-2905.01 or 36-2905.02; or~~
~~2. Certification of a person or household that is ineligible at the time of certification because:~~
   ~~a. The household's annual income exceeds the limits specified in A.R.S. § 11-297, 36-2905, or 36-2905.03;~~
   ~~b. The household's resources exceed the limits specified in A.R.S. §§ 11-297, 36-2905, and 36-2905.03;~~
   ~~c. The household member transfers resources, except as permitted under R9-22-1628, for the purpose of meeting the resource limits specified in A.R.S. §§ 11-297, 36-2905, and 36-2905.03;~~
   ~~d. The person is not a resident of Arizona under A.R.S. § 36-2903.01;~~
   ~~e. The person is not a citizen of the United States or a qualified alien under R9-22-1624. This requirement does not apply to SESP;~~
   ~~f. The person is enrolled or eligible to be enrolled to receive Medicare-covered services through a managed care organization, except if the person receives a transplant as specified in A.R.S. § 36-2905(J) or is prohibited from enrolling in a Medicare HMO as specified in R9-22-1611;~~
   ~~g. The person is 1 of the following as specified in R9-22-1616:~~
      ~~i. An inmate in a public institution,~~
      ~~ii. A patient in a public mental hospital,~~
      ~~iii. Deceased,~~
      ~~iv. An AHCCCS-disqualified spouse,~~
      ~~v. An AHCCCS-disqualified dependent, or~~
      ~~vi. A current recipient of benefits under Title XIX or Title XXI of the Social Security Act;~~
   ~~h. A person refuses to cooperate with the Title XIX or Title XXI eligibility process as required under A.R.S. §§ 11-297, 36-2905, and 36-2905.03;~~
   ~~i. The county eligibility department did not screen and refer the person for potential eligibility for Title XIX or Title XXI under A.R.S. §§ 36-2905 and 36-2983; or~~
   ~~j. The person is potentially eligible for S.O.B.R.A., and neither of the conditions in R9-22-1610(E)(1) or (E)(3)(c) is met.~~

~~**B.** Challenge of certification errors by county eligibility department.~~

~~1. Challenge process.~~

~~a. "Quality control case report" means the report of findings for an individual case record which the Administration issues to the county eligibility department following a quality control sample review.~~
~~b. A county eligibility department may challenge the Administration quality control finding of a certification error by submitting a written challenge to the Administration postmarked no later than 30 days from the postmark date of the quality control case report. A county eligibility department's challenge shall include evidence that refutes the quality control finding of a certification error. A county eligibility department may include evidence obtained after the date of the quality control case report.~~
~~c. The Administration's quality control finding of a certification error shall be final if a county eligibility department fails to submit a challenge under the time-frame in subsection (B)(1)(b).~~

~~2. Challenge review.~~
~~a. The Administration shall review a county eligibility department's challenge and either uphold or overturn a quality control finding of a certification error.~~
~~b. The Administration shall only consider evidence submitted by the Administration's quality control staff and the county eligibility department.~~
~~c. The Administration shall overturn a quality control finding of a certification error if a preponderance of the evidence establishes that a person was eligible for AHCCCS benefits at the time of certification.~~
~~d. If the Administration overturns a quality control finding of a certification error, the Administration shall not consider a case record an error in calculating a county eligibility department's error rate under A.R.S. § 36-2905.01(A).~~

~~3. Hearings. A county eligibility department may appeal the Administration's decision under Article 8.~~

~~C. Corrective action plan.~~
~~1. "Statewide summary report" means the report of all quality control sample review findings by county for all case records reviewed statewide for any review period. The Administration issues the report to each county eligibility department on a semi-annual basis.~~
~~2. Submittal of a corrective action plan. A county eligibility department in a county with a certification error rate greater than 3%, calculated under A.R.S. § 36-2905.01(A), shall prepare a corrective action plan if the county eligibility department has not completed 1 in the last 12 months. The county eligibility department shall submit to the Administration a corrective action plan that is postmarked no later than 90 days from the postmark date of the Administration's statewide summary report.~~
~~3. Content of a corrective action plan.~~
~~a. A corrective action plan shall include procedures that a county eligibility department will use to:~~
~~i. Identify certification errors,~~
~~ii. Analyze the frequency of certification errors,~~
~~iii. Analyze the cause of certification errors,~~
~~iv. Develop and implement corrective actions to prevent certification errors, and~~
~~v. Identify procedures for evaluating the effectiveness of the corrective action plan.~~
~~b. For each corrective action, a corrective action plan shall include a narrative summary that contains:~~
~~i. A statement identifying each certification error addressed by the corrective action,~~
~~ii. An estimate of the certification error percentage caused by an identified error,~~
~~iii. A summary explaining how each certification error was discovered by the Administration,~~
~~iv. A description of the county eligibility department's procedures in use when each certification error occurred,~~
~~v. A description of a subsequent or proposed change to correct each certification error,~~
~~vi. A summary of the expected certification error rate reduction resulting from implementation of the corrective action, and~~
~~vii. An estimate of when the county eligibility department expects to achieve the certification error rate reduction.~~
~~c. For each corrective action, a corrective action plan shall include a work plan that identifies:~~
~~i. Major activities or action steps planned to implement the corrective action,~~
~~ii. A person responsible for each activity or action step,~~
~~iii. A proposed timetable for implementing each activity or action step listed in the work plan,~~
~~iv. A person who will monitor implementation of the work plan, and~~
~~v. A method for evaluating the effectiveness of the work plan.~~

~~D. Recovery of costs. If a county's certification error rate exceeds 3%, the Administration shall recover costs as defined in A.R.S. § 36-2905.01.~~

A. This Article defines the responsibilities, structure, and requirements of the Medicaid Eligibility Quality Control program (MEQC) which are further delineated in the Intergovernmental Agreement (IGA) under A.R.S. § 36-2903.01 between the Administration and the Department.

B. The Administration conducts MEQC activities to:

1. Determine the Department's compliance with the IGA,
2. Prevent or detect an eligibility error, and
3. Determine compliance with performance measures.

C. The Administration shall select cases, under Sections R9-22-903 through R9-22-905, for review on a monthly basis from eligibility determinations made in the previous month within each six-month review period. Each six-month review period sample will be statistically valid at 95 percent confidence level on a statewide or district basis in accordance with AHCCCS' Quality Control Redesign Pilot as approved by CMS.

R9-22-902. ~~Quality Control Case Analysis~~ Pre-Determination Quality Control (PDQC)

~~**A.** Certification error. To identify certification errors, the Administration may conduct a quality control case analysis under A.R.S. § 36-2905.02. In addition to certification errors described in R9-22-901(A), a certification error for a quality control case analysis includes:~~

~~1. Improper classification of a person as MI/MN if the person meets only the criteria for ELIC; or~~
~~2. A county eligibility department's failure to take timely action to discontinue benefits when appropriate, under R9-22-1615, after receiving information containing cause for ineligibility.~~

~~**B.** Challenge process. Except for R9-22-901(B)(2)(d), the challenge process described in R9-22-901(B) applies to a quality control case analysis with the following additions:~~

~~1. If a county eligibility department claims that a certification decision was based on fraudulent information, a county eligibility department shall establish the existence of fraudulent information by clear and convincing evidence.~~
~~2. The Administration shall overturn a quality control finding if clear and convincing evidence establishes that a county eligibility department's certification decision was based on fraudulent information.~~
~~3. If the Administration overturns a finding, the Administration shall withdraw any associated penalties.~~

~~**C.** Recovery of cost for covered services. The Administration shall recover costs for covered services under A.R.S. § 36-2905.02. The following conditions apply:~~

~~1. A county shall reimburse the Administration for capitation, claims, and reinsurance paid to a contractor as a result of a certification error.~~
~~2. A county shall reimburse a provider or nonprovider that incurred or paid an expense not already paid by the Administration, including an expense in excess of the capitation.~~
~~3. A county may file a grievance concerning the amount of a financial penalty resulting from a quality control case analysis under Article 8.~~
~~4. If the Director issues a decision in favor of a county, and the Administration has recovered the cost of services under A.R.S. § 36-2905.02, the Administration shall refund to the county an amount specified by the Director.~~

A. The Department shall screen Title XIX applications, provide PDQC referrals to the Administration, and comply with the PDQC requirements.

B. The Administration may conduct a case review prior to a determination of eligibility in order to avoid an error and prevent fraud.

C. The Department shall compare the Administration's review findings with information received during and after an interview under Article 14 and with previous applications to determine whether or not an individual or family is eligible based on a preponderance of evidence.

R9-22-903. ~~Repealed~~ Random Sample

A. The Administration shall select a case from a statistically valid random sample of all cases approved or active for Title XIX during a review period, conduct a case review, and issue a Notice of Finding to the Department.

B. The Administration may stratify cases by district.

R9-22-904. ~~Repealed~~ Targeted Sample

A. The Administration may conduct a targeted case review based on specific criteria and issue a Notice of Finding to the Department.

B. The Administration shall select a sample for a targeted review either on a random basis or on an individual case basis. The criteria may be by case characteristics, individual office or district, or other criteria determined by the Administration.

R9-22-905. ~~Repealed~~ Negative Case Action Sample

A. The Administration shall select a case from a statistically valid random sample of all cases denied or discontinued from Title XIX during a review period, conduct a case review, and issue a Notice of Finding to the Department.

B. The Administration may stratify cases by district.

R9-22-906. ~~Repealed~~ Management Evaluation Review

A. The Administration shall perform a Management Evaluation Review of the Department under A.R.S. § 36-2903.01 to determine whether the performance measures are being met and include any findings in the Summary Report to the Department. No less than 12 Department eligibility sites will be reviewed annually.

B. The Management Evaluation Reviews may include:

1. Interviews with applicants, members and Department staff,
2. Observation of local office practices,
3. Reviews of notices sent to an applicant and a member,
4. Reviews of pre-enrollment procedures,
5. Other areas of the eligibility process for which the Department is responsible,
6. The eligibility appeal process, or
7. Interviews with department staff located in or staff employed by Federally Qualified Health Centers and Level One Trauma Centers to identify any barriers, including sufficient staffing, that delay the processing of applications.

R9-22-907. ~~Repealed~~ Challenge of Findings

A. Challenge Process.
1. The Department may challenge the Administration's error finding under R9-22-903 through R9-22-905 by submitting a written challenge to the Administration. The Administration shall receive the challenge no later than 15 days from the date of the Notice of Finding. The date of the Notice of Finding is the date the Notice is mailed.
2. The Department shall include evidence that refutes an error finding. The Department may include in its written challenge evidence obtained after the date of the Notice of Finding.
3. The Administration's finding shall be final if the Department fails to submit a challenge under the timeframe in subsection (A)(1).

B. Administration Decision.
1. The Administration shall review, within 30 days of receipt, the Department's challenge of an error finding and either uphold or overturn a finding.
2. The Administration shall overturn an error finding if a preponderance of the evidence establishes that the Department's decision was not an error.
3. The Administration shall not consider a case an error in calculating the Department's error rate under R9-22-909(A) if the Administration overturns a finding.
4. The Department may file a grievance under Article 8 concerning the Administration's decision.

R9-22-908. ~~Repealed~~ Corrective Action Plans

A. The Administration shall issue a Summary Report to the Department following the completion of each review period.

B. The Department shall prepare and implement a corrective action plan if the Summary Report identifies an error rate greater than the tolerance level either statewide or by district or the Department fails to meet the performance measures delineated in the IGA.

C. The Department shall prepare, submit, and implement an effective corrective action plan for the Administration's finding under R9-22-906 when an office does not meet a level of compliance.

R9-22-909. ~~Repealed~~ Annual Assessment Period Report

The Administration shall issue an Annual Assessment Period Report. This report shall:

A. Serve as notification to the Department of the annual error rate determined for the Random Sample, Targeted Sample and Negative Case Action Sample,

B. Compare the error rate with the tolerance level for each sample, and

C. Serve as notification to the Department of a disallowed error rate and applicable financial sanction under A.R.S. § 36-2903.01.

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

R9-22-1201. General Requirements

General requirements. The following general requirements apply to behavioral health services provided under this Article, subject to all exclusions and limitations.

1. Administration. The program shall be administered as specified in A.R.S. § 36-2903.
2. Provision of services. Behavioral health services shall be provided as specified in A.R.S. § 36-2907 and this Chapter.
3. Definitions. The following definitions apply to this Article:
   - ~~a. "Alternative Residential Care Facility" means an ADHS-licensed facility with 16 or fewer beds. Alternative residential care facilities include Level I facilities licensed to provide emergency services, or detoxification services, or Level II and III facilities.~~
   - ~~b. "Emergency or crisis behavioral health services" specified in 9 A.A.C. 20.~~
   - ~~c. "Health plan" means a plan that contracts directly with AHCCCS to provide services specified by contract under the requirements of the contract and this Article.~~
   - ~~d. "Physician assistant" specified in A.R.S. § 32-2501. In addition, a physician assistant providing a behavioral health service shall be supervised by an AHCCCS-registered psychiatrist.~~
   - ~~e. "TRBHA" means a Tribal Regional Behavioral Health Authority.~~

a. "Case management" means supportive services and activities that enhance treatment, compliance, and effectiveness of treatment.
b. "Physician assistant" specified in A.R.S. § 32-2501. In addition, a physician assistant providing a behavioral health service shall be supervised by an AHCCCS-registered psychiatrist.
c. "Respite" means a period of care and supervision of a member to provide an interval of rest or relief to a family member or other person caring for the member. Respite provides activities and services to meet the social, emotional, and physical needs of the member during the respite period.
d. "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 dependence and impaired mental, social or educational functioning. Nicotine addiction is not a considered substance abuse for adults who are 21 years of age or older.
e. "TRBHA" means a Tribal Regional Behavioral Health Authority.
f. "Therapeutic foster care services" means services provided in a licensed foster home by qualified and trained foster parents who implement the in-home portion of a member's behavioral health treatment plan. The implementation of the plan allows the member to remain in the community versus requiring more intensive level of services.

R9-22-1202. ADHS and ~~Health Plan~~ Contractor Responsibilities

A. ADHS responsibilities. Behavioral health services shall be provided by an a RBHA through a contract with ADHS. ADHS shall:
1. Contract with an a RBHA for the provision of behavioral health services in R9-22-1205 for all Title XIX members as specified in under A.R.S. § 36-2907. ADHS shall ensure that an a RBHA provides behavioral health services to members directly, or through subcontracts, with qualified service providers who meet the qualifications specified in R9-22-1206. If behavioral health services are unavailable within an a RBHA's service area, ADHS shall ensure that an a RBHA provides behavioral health services to a Title XIX member outside the RBHA's service area.
~~2. Diagnose and evaluate a child who may be in need of behavioral health services for an eligibility determination, and who is not already enrolled with Title XIX or Title XXI under A.R.S. §§ 36-2901 (4)(b), 36-2931, or 36-2981.~~
~~3.~~2. Ensure that a member's behavioral health service is provided in collaboration with a member's primary care provider.
~~4.~~3. Coordinate the transition of care and medical records, ~~specified in~~ under A.R.S. §§ 36-2903, 36-509, A.A.C. R9-22-512, and in contract, when a member transitions from:
   a. A behavioral health provider to another behavioral health provider,
   b. ~~An~~ A RBHA to another RBHA,
   c. ~~An~~ A RBHA to a health plan contractor,
   d. A ~~health plan~~ contractor to an a RBHA, or
   e. A ~~health plan~~ contractor to another health plan contractor.

B. ADHS may contract with a TRBHA for the provision of behavioral health services for Native American members. In the absence of a contract with ADHS, Native American members may:
1. Receive behavioral health services from an IHS facility or a TRBHA, or
2. Be referred off-reservation to an a RBHA for covered behavioral health services.

C. ~~Health plan~~ Contractor responsibilities. A health plan contractor shall:
1. Refer a member to an a RBHA according to under the contract terms;
2. Provide EPSDT developmental and behavioral health screening specified in R9-22-213;
3. Provide inpatient emergency behavioral health services specified in R9-22-1205 for a member not yet enrolled with ~~an~~ a RBHA;
4. Provide psychotropic medication services for a member, in consultation with the member's RBHA as needed, for behavioral health conditions specified in contract and within the primary care provider's scope of practice; and
5. Coordinate a member's transition of care and medical records specified in under R9-22-1202.

R9-22-1203. Eligibility for Covered Services

A. Title XIX members. A member determined eligible ~~according to~~ under A.R.S. § ~~36-2901(4)(b)~~ 36-2901(6)(a), shall receive medically necessary covered services ~~specified in~~ under R9-22-1205.

B. FES members. A person who would be eligible under A.R.S. § ~~36-2901(4)(b)~~ 36-2901(6)(a)(i), A.R.S. § 36-2901(6)(a)(ii), and A.R.S. § 36-2901(6)(a)(iii) except for the failure to meet the U.S. citizenship or qualified alien status requirements ~~prescribed in~~ under A.R.S. § ~~36-2903.03~~ 36-2903.03(A) and A.R.S. § 36-2903.03(B) or A.R.S. § 36-2903.03(C) is eligible for emergency services only.

~~**C.** State-funded members. A member determined eligible according to A.R.S. §§ 36-2901(4)(a), (c), (h), or (j), 36-2905.03, and 36-2905.05 shall receive only emergency behavioral health services, as specified in R9-22-204(A). The emergency behavioral health services shall be provided through a health plan or an AHCCCS-registered FFS provider.~~

~~**D.**~~**C.** Ineligibility. A person is not eligible for behavioral health services if the person is:

1. An inmate of a public institution as defined in 42 CFR 435.1009,
2. A resident of an institution for the treatment of tuberculosis, or
3. Age 21 through 64~~, and~~ who is a resident of an IMD, and exceeds the limits under R9-22-1205.

R9-22-1204. General Service Requirements

A. Services. Behavioral health services include both mental health and substance abuse services.

B. Medical necessity. A service shall be medically necessary as ~~specified in~~ under R9-22-201.

C. Prior authorization. A service shall be provided by contractors, subcontractors, and providers consistent with the prior authorization requirements established by the Director and ~~specified in~~ under R9-22-210 and R9-22-1205.

D. EPSDT. For Title XIX members under age 21, EPSDT services shall include all medically necessary Title XIX-covered services that are necessary to provide behavioral health services to a member.

E. Experimental services. The Director shall determine if a service is experimental, or whether a service is provided primarily for the purpose of research. Those services shall not be covered.

F. Gratuities. A service or an item, if furnished gratuitously to a member, is not covered and payment shall be denied to a provider.

G. Service area. Behavioral health services rendered to a member shall be provided within the RBHA's service area except when:
1. A ~~health plan's~~ contractor's primary care provider refers a member to another area for medical specialty care,
2. A member's medically necessary covered service is not available within the service area, or
3. A net savings in behavioral health service delivery costs can be documented by the RBHA for a member. Undue travel time or hardship shall be considered for a member or a member's family.

H. Travel. If a member travels or temporarily resides out of a behavioral health service area, covered services are restricted to emergency behavioral health care, unless otherwise authorized by the member's RBHA.

I. Non-covered services. If a member requests a behavioral health service that is not covered by AHCCCS or is not authorized by ~~an~~ a RBHA, the behavioral health service may be provided by an AHCCCS-registered behavioral health service provider under the following conditions:
1. The requested service and the itemized cost of each service is documented and provided to the member or member's guardian; and
2. The member or the member's guardian signs a statement acknowledging:
   a. Services have been explained to the member or member's guardian, and
   b. The member or member's guardian accepts responsibility for payment.

J. Referral. If a member is referred out of ~~an~~ a RBHA service area to receive an authorized medically necessary behavioral health service or a medically necessary covered service the services shall be provided by the ~~health plan~~ contractor or RBHA.

K. Restrictions and limitations. ~~The restrictions, limitations, and exclusions in this Article shall not apply to a health plan or an RBHA when electing to provide a noncovered service.~~
1. The restrictions, limitations, and exclusions in this Article shall not apply to a contractor or a RBHA when electing to provide a noncovered service.
2. Room and board is not a covered service unless provided in an inpatient, sub-acute, or residential facility under R9-22-1205.

~~**L.** Residential settings. Partial care, outpatient, emergency services, and other behavioral health services shall be covered if medically necessary, when provided in a residential setting by a licensed provider. Room and board is not a covered service unless provided in an inpatient facility specified in R9-22-1205(B).~~

R9-22-1205. Scope and Coverage of Behavioral Health Services

A. Inpatient behavioral health services.The following inpatient services shall be covered subject to the limitations and exclusions in this Article.
1. Inpatient behavioral health services provided in a Medicare (Title XVIII) certified hospital include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment. The behavioral health service shall be provided under the direction of a physician in:
   a. A general acute care ~~hospital;~~ hospital, or
   b. An inpatient psychiatric ~~facility for a person under 21 years of age, licensed as a psychiatric hospital, or a residential treatment center, licensed as a Level I Psychiatric Facility and accredited by an AHCCCS-approved accrediting body as specified in contract and authorized by federal laws and regulations; or~~ hospital.
   ~~c. An IMD for a member under age 21 or 65 years of age and older, licensed as a psychiatric hospital or a NF.~~
2. Inpatient service limitations:
   a. Inpatient services, other than emergency services specified in this Section, shall be prior authorized.
   b. Inpatient services and room and board shall be reimbursed on a per diem basis and shall be inclusive of all services, except the following may bill independently for services:
      i. A psychiatrist,

ii. A certified psychiatric nurse practitioner,
iii. A physician assistant, ~~as defined in this Article, or~~
iv. A ~~psychologist.~~ psychologist,
v. A certified independent social worker,
vi. A certified marriage and family therapist,
vii. A certified professional counselor, or
viii. A behavioral health medical practitioner.

~~c. The following services may be billed independently if prescribed by a provider specified in R9-22-1205(B)(1)(b) for a member residing in a residential treatment center:~~
~~i. Laboratory,~~
~~ii. Radiology, and~~
~~iii. Psychotropic medications.~~

~~d.~~c. A member age 21 through 64 ~~defined in 42 CFR 441.150~~ is ~~not~~ eligible for behavioral health services provided in ~~an IMD except as specified in 42 CFR 441.151.~~ a hospital listed in Section (A)(1)(b) that meets the criteria for an IMD up to 30 days per admission and no more than 60 days per contract year as allowed under the Administration's Section 1115 Waiver with CMS.

~~**B.** Partial care. The following partial care services shall be covered subject to the limitations and exclusions in this Article.~~
~~1. Partial care shall be provided as either a basic or intensive level of care to:~~
~~a. Meet a member's need for behavioral health treatment, and~~
~~b. Prevent placing a member in a higher level of care or a more restrictive environment.~~
~~i. Basic partial care services shall be provided as specified in 9 A.A.C. 20.~~
~~ii. Intensive partial care services shall be provided as specified in 9 A.A.C. 20.~~
~~2. Partial care service limitations. All services shall be included in the partial care reimbursement rate, practitioners may bill independently:~~
~~a. A psychiatrist,~~
~~b. A certified psychiatric nurse practitioner,~~
~~c. A physician assistant as defined in this Article, and~~
~~d. A psychologist.~~

~~**C.** Outpatient services. The following outpatient services shall be covered subject to the limitations and exclusions in this Article.~~
~~1. Outpatient services shall include the following:~~
~~a. Screening provided by a behavioral health professional or a behavioral health technician;~~
~~b. Evaluation provided by a behavioral health professional;~~
~~c. Counseling including individual therapy, group, and family therapy provided by a behavioral health professional or a behavioral health technician under the clinical supervision of a behavioral health professional;~~
~~d. Behavior management provided by a behavioral health professional, a behavioral health technician, or a behavioral health paraprofessional; and~~
~~e. Psychosocial rehabilitation provided by a behavioral health professional, a behavioral health technician, or a behavioral health paraprofessional.~~
~~2. Outpatient service limitations:~~
~~a. The following practitioners may bill independently:~~
~~i. A psychiatrist,~~
~~ii. A certified psychiatric nurse practitioner,~~
~~iii. A physician assistant as defined in this Article, and~~
~~iv. A psychologist.~~
~~b. Other behavioral health professionals, behavioral health technicians, and behavioral health paraprofessionals not specified in subsection (D)(2)(a) shall be employed by, or contracted with, an AHCCCS-registered behavioral health agency.~~

~~**D.** Behavioral health emergency services. The following emergency services are covered subject to the limitations and exclusions in this Article.~~
~~1. An RBHA shall ensure that behavioral health emergency services are provided by the qualified personnel specified in R9-22-1206. The emergency services shall be available 24 hours-per-day, 7 days-per-week in the RBHA's service area in emergency situations when a member is a danger to self or others or is otherwise determined in need of immediate unscheduled behavioral health services. Behavioral health emergency services may be provided on either an inpatient or outpatient basis.~~
~~2. A health plan shall provide behavioral health emergency services on an inpatient basis not to exceed 3 days per emergency episode and 12 days per contract year, for a member not yet enrolled with an RBHA.~~

~~3. An inpatient emergency service provider shall verify the eligibility and enrollment of a member through the Administration to determine the need for notification to a health plan or an RBHA and to determine the party responsible for payment of services under Article 7.~~
~~4. Behavioral health emergency service limitations:~~
~~a. An emergency behavioral health service does not require prior authorization. The provider shall, however, comply with the notification requirements specified in R9-22-210.~~
~~b. A behavioral health service for an unrelated condition, that requires evaluation, diagnosis, and treatment shall be prior authorized by an RBHA.~~

~~**E.** Other behavioral health services. Other behavioral health services include:~~
~~1. Case management as defined in R9-22-112;~~
~~2. Laboratory and radiology services for behavioral health diagnosis and medication management;~~
~~3. Psychotropic medication and related medication included in a health plan's or an RBHA's formulary; and~~
~~4. Medication monitoring, administration, and adjustment for psychotropic medication and related medications.~~

~~**F.** Transportation services.~~
~~1. Emergency transportation shall be covered for a behavioral health emergency specified in R9-22-211. Emergency transportation is limited to behavioral health emergencies.~~

B. Level I Residential Treatment Center Services. The following Residential Treatment Center services shall be covered subject to the limitations and exclusions under this Article.
1. Level I Residential Treatment Center services shall be provided under the direction of a physician in a Level I Residential Treatment Center accredited by an AHCCCS approved accrediting body as specified in contract.
2. Residential Treatment Center services include room and board and treatment services for mental health and substance abuse conditions.
3. Residential Treatment Center service limitations:
   a. Services shall be prior authorized, except for emergency services as specified in this Section.
   b. Services shall be reimbursed on a per diem basis and shall be inclusive of all services, except the following may bill independently for services:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant,
      iv. A psychologist,
      v. A certified independent social worker,
      vi. A certified marriage and family therapist,
      vii. A certified professional counselor, or
      viii. A behavioral health medical practitioner.
4. The following services may be billed independently if prescribed by a provider specified in this Section:
   a. Laboratory,
   b. Radiology, and
   c. Psychotropic medication.

C. Level I Sub-acute Facility Services. The following sub-acute facility services shall be covered subject to the limitations and exclusions under this Article.
1. Level I sub-acute facility services shall be provided under the direction of a physician in a Level I sub-acute facility accredited by an AHCCCS approved accrediting body as specified in contract.
2. Level I sub-acute services include room and board and treatment services for mental health and substance abuse conditions.
3. Services shall be reimbursed on a per diem basis and shall be inclusive of all services, except the following may bill independently for services:
   a. A psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A physician assistant,
   d. A psychologist,
   e. A certified independent social worker,
   f. A certified marriage and family therapist,
   g. A certified professional counselor, or
   h. A behavioral health medical practitioner.
4. The following services may be billed independently if prescribed by a provider specified in this Section:
   a. Laboratory,
   b. Radiology, and
   c. Psychotropic medication.

5. A member age 21 through 64 is eligible for behavioral health services provided in a subacute facility that meets the criteria for an IMD for up to 30 days per admission and no more than 60 days per contract year as allowed under the Administrations's Section 1115 Waiver with CMS.

D. ADHS licensed Level II Behavioral Health Residential Services. The following Level II Behavioral Health Residential services shall be covered subject to the limitations and exclusions in this Article.
1. Level II Behavioral Health services shall be provided by a licensed Level II agency.
2. Services shall be inclusive of all covered services except room and board.
3. The following may bill independently for services:
   a. A psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A physician assistant,
   d. A psychologist,
   e. A certified independent social worker,
   f. A certified marriage and family therapist,
   g. A certified professional counselor, or
   h. A behavioral health medical practitioner.

E. ADHS licensed Level III Behavioral Health Residential Services. The following Level III Behavioral Health Residential services shall be covered subject to the limitations and exclusions under this Article.
1. Level III Behavioral Health services shall be provided by a licensed Level III agency.
2. Services shall be inclusive of all covered services except room and board.
3. The following may bill independently for services:
   a. A psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A physician assistant,
   d. A psychologist,
   e. A certified independent social worker,
   f. A certified marriage and family therapist,
   g. A certified professional counselor, or
   h. A behavioral health medical practitioner.

F. Partial care. The following partial care services shall be covered subject to the limitations and exclusions in this Article.
1. Partial care shall be provided by an agency qualified to provide a regularly scheduled day program of individual member, group or family activities that are designed to improve the ability of the member to function in the community.
2. Partial care service exclusions. School attendance and educational hours shall not be included as a partial care service and shall not be billed concurrently with these services.

G. Outpatient services. The following outpatient services shall be covered subject to the limitations and exclusions in this Article.
1. Outpatient services shall include the following:
   a. Screening provided by a behavioral health professional or a behavioral health technician;
   b. Initial behavioral health evaluation provided by a behavioral health professional;
   c. Ongoing behavioral health evaluation by a behavioral health professional or a behavioral health technician;
   d. Counseling including individual therapy, group, and family therapy provided by a behavioral health professional or a behavioral health technician;
   e. Behavior management services provided by qualified individuals or agencies as specified in contract; and
   f. Psychosocial rehabilitation services provided by qualified individuals or agencies as specified in contract.
2. Outpatient service limitations:
   a. The following practitioners may bill independently:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant as defined in this Article,
      iv. A psychologist,
      v. A certified independent social worker,
      vi. A certified professional counselor,
      vii. A certified marriage and family therapist,
      viii. A behavioral health medical practitioner,
      ix. A therapeutic foster parent, and
      x. Other AHCCCS registered providers as specified in contract.
   b. Other behavioral health professionals and qualified persons not specified in subsection (G)(2)(a) shall be employed by, or contracted with, an AHCCCS-registered behavioral health agency.

H. Behavioral health emergency services. The following emergency services are covered subject to the limitations and exclusions under this Article.
1. A RBHA shall ensure that behavioral health emergency services are provided by the qualified personnel under R9-22-1206. The emergency services shall be available 24 hours-per-day, seven days-per-week in the RBHA's service area in emergency situations when a member is a danger to self or others or is otherwise determined in need of immediate unscheduled behavioral health services. Behavioral health emergency services may be provided on either an inpatient or outpatient basis.
2. A contractor shall provide behavioral health emergency services under R9-22-210(D) on an inpatient basis not to exceed three days per emergency episode and 12 days per contract year, for a member not yet enrolled with a RBHA.
3. An inpatient emergency service provider shall verify the eligibility and enrollment of a member through the Administration to determine the need for notification to a contractor or a RBHA and to determine the party responsible for payment of services under Article 7.
4. Behavioral health emergency service limitations:
   a. An emergency behavioral health service does not require prior authorization. The provider shall, however, comply with the notification requirements under R9-22-210.
   b. A behavioral health service for an unrelated condition, that requires evaluation, diagnosis, and treatment shall be prior authorized by a RBHA.

I. Other behavioral health services. Other behavioral health services include:
1. Case management as defined in R9-22-1201;
2. Laboratory and radiology services for behavioral health diagnosis and medication management;
3. Psychotropic medication and related medication;
4. Medication monitoring, administration, and adjustment for psychotropic medication and related medications;
5. Respite care;
6. Therapeutic foster care services provided in a family foster home defined in 6 A.A.C. 5, Article 58 or adult therapeutic foster home defined in 9 A.A.C. 20 Articles 1 and 15;
7. Personal assistance; and
8. Other support services to maintain or increase the member's self-sufficiency and ability to live outside an institution.

J. Transportation services.
1. Emergency transportation shall be covered for a behavioral health emergency under R9-22-211. Emergency transportation is limited to behavioral health emergencies.
2. Non-emergency transportation shall be covered to and from covered behavioral health service providers.

R9-22-1206. General Provisions and Standards for Service Providers

A. Qualified service provider. A qualified behavioral health service provider shall:
1. Be a non-contracting provider or employed by, or contracted in writing with, ~~an~~ a RBHA or a ~~health plan~~ contractor to provide behavioral health services to a member;
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; and
4. Comply with all requirements ~~specified in~~ under Article 5 and this Article.

B. Quality and utilization management.
1. Service providers shall cooperate with the quality and utilization management programs of ~~an~~ a RBHA, a ~~health plan~~ contractor, ADHS, and the Administration ~~according to~~ under R9-22-522 and contract.
2. Service providers shall comply with applicable procedures ~~specified in 42 CFR 456, August 23, 1996, 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.~~ under 42 CFR 456

ARTICLE 14. ~~TITLE IV-A RELATED ELIGIBILITY~~ AHCCCS MEDICAL COVERAGE FOR FAMILIES AND INDIVIDUALS

R9-22-1401. ~~Scope and Applicability~~ General Information

~~**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.~~

This Article contains eligibility criteria to determine if a family or individual is eligible for AHCCCS medical coverage.

R9-22-1402. ~~Agency Responsible for Determining Eligibility~~ Ineligible Person

~~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.~~

A person is not eligible for AHCCCS medical coverage if the person is:

1. An inmate of a public institution if federal financial participation (FFP) is not available, or
2. Age 21 through age 64 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except when allowed under the Administration's Section 1115 IMD waiver with CMS.

R9-22-1403. ~~Confidentiality~~ Agency Responsible for Determining Eligibility

~~The confidentiality provisions in A.A.C. R6-12-102 apply to this Article.~~

The Department shall determine eligibility under the provisions of this Article. The Department 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 U.S.C., Section 2000d, and rules and regulations promulgated according to, or as otherwise provided by law.

R9-22-1404. ~~Case Record~~ Confidentiality

~~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.~~

The Administration and Department shall maintain the confidentiality of an applicant's or member's records and shall not disclose an applicant's or member's financial, medical, or other confidential information except as allowed under R9-22-512 and 6 A.A.C.12, Article 1.

R9-22-1405. ~~Manuals~~ Application Process

~~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.~~

A. Right to apply. A person, identified in subsection (B), may apply for AHCCCS medical coverage by submitting a signed Department approved application to any FAA office or outstation location listed below:
   1. A BHS site as provided in Laws 1991, Chapter 213, § 21;
   2. A CRS site as provided in Laws 1991, Chapter 213, § 21;
   3. A Baby Arizona approved provider's office, if the applicant is a pregnant woman;
   4. A FQHC or disproportionate share hospital as required by 42 CFR 435.904;
   5. A hospital; or
   6. Any other site approved by the Department or the Administration.

B. Who may apply for a person.
   1. The applicant, a minor applicant's parent, or the applicant's legal or authorized representative may apply for AHCCCS medical coverage. An application shall be witnessed and signed by a third-party, if an applicant signs an application with a mark.
   2. The applicant may designate an authorized representative either verbally in the presence of a Department employee or in writing.
   3. If the applicant is incompetent or incapacitated, someone acting responsibly on behalf of the applicant may apply for AHCCCS medical coverage. Incapacity shall be verified by written documentation signed by a licensed physician, physician assistant, nurse protactinium, or a registered nurse under the direction of a licensed physician.

C. Date of Application.
   1. The date of application is the date a signed application is received at a location listed in subsection (A).
   2. An application shall be accepted if the application contains the legible name and address of each person requesting AHCCCS medical coverage and the signature of the person listed in subsection (B) who submitted the application. The Department shall accept an application and assign a name and address for a person who is incompetent or incapacitated and whose name and address are not known.
   3. Except for the MED program under R9-22-1427 through R9-22-1432 and a newborn under R9-22-1422, the effective date of eligibility is:
      a. The first day of the month that the applicant files an application if the applicant is eligible that month, or
      b. The first day of the first eligible month following the application month.

D. Complete application. A complete application shall contain information listed in subsection (C), the names of all persons living with the applicant, and the relationship of those persons to the applicant, and all eligibility information requested on the application form.

E. Assistance with application. The Department shall allow a person of the applicant's choice to accompany, assist, and represent the applicant in the application process.

F. Applicants who die. 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.

G. Deceased applicants. The Department shall complete an eligibility determination on an application filed on behalf of a deceased applicant, provided the application is filed in the month of the person's death.

R9-22-1406. ~~Eligibility Coverage Groups and an Eligible Applicant~~ Applicant and Member Responsibility

~~**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 non-parent 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.~~

A. An applicant and member shall authorize the Department to obtain verification.

B. As a condition of eligibility, an applicant and member shall:
1. Give the Department complete and truthful information. The Department may deny an application or discontinue eligibility if:
   a. The applicant or member fails to provide information necessary for initial or continuing eligibility,
   b. The applicant or member fails to provide the Department with written authorization to permit the Department to obtain necessary verification,
   c. The applicant or member fails to provide verification under R9-22-1410 after the Department had made an effort to obtain the necessary verification but has not obtained the necessary information, or
   d. The applicant or member does not assist the Department in resolving incomplete, inconsistent, or unclear information that is necessary for initial or continuing eligibility.
2. Comply with the DCSE under 42 CFR 433.148 in establishing paternity and enforcing medical support obligations when requested. The Department shall not deny AHCCCS eligibility to any applicant who would otherwise be eligible and who is a minor child and whose parent or legal representative does not cooperate with the medical support requirements under subsection (E) or first-and third-party liability under Article 10;
3. Provide information concerning third-party coverage for medical care;

C. The member shall:
1. Send to the Department any medical support payments received resulting from a medical support order while the member is eligible;
2. Cooperate with the Administration regarding any issues arising under the Medicaid Eligibility Quality Control Program under Article 9; and

3. Inform the Department of the following changes within 10 days from the date the applicant or member knows of a change:
   a. In address,
   b. In the household's composition,
   c. In income,
   d. In resources, when required for the Medical Expense Deduction (MED) program under R9-22-1430,
   e. In Arizona state residency,
   f. In citizenship or immigrant status,
   g. In first- or third-party liability which may contribute to the payment of all or a portion of the person's medical costs, or
   h. That may affect the person's eligibility including a change in a woman's pregnancy status.

D. As a condition of eligibility, an applicant or member shall apply for other benefits as required under 42 CFR 435.608.

E. As a condition of eligibility, an applicant or member shall cooperate with the Assignment of Rights and if the applicant or member receives first- or third-party care and services, the applicant or member shall:
1. Cooperate with the Department and the Administration in identifying and providing information to assist the state in pursuing any first or third party who may be liable to pay for medical care and services.
2. Except as provided in subsections (3) and (4), a parent, legal representative, or other legal responsible adult who applies for AHCCCS medical coverage on behalf of a child shall cooperate with the Department to establish paternity and obtain medical support or other payments as provided in A.R.S. § 46-292(C).
3. A pregnant woman under A.R.S. § 36-2901(6)(a)(ii) is not required to provide the Department with information regarding paternity or medical support from a father of a child born out of wedlock.
4. A parent, who is not requesting AHCCCS medical coverage, is not required to provide the Department with information regarding paternity or medical support from an absent parent.

F. At an initial application interview and at any review, the Department shall explain to the applicant or member the following requirements:
1. To comply with DCSE in establishing paternity and enforcing medical support except in circumstances when good cause under 42 CFR 433.147 exists for not cooperating,
2. To establish good cause for not complying with DCSE in establishing paternity and enforcing medical support,
3. To report a change listed in subsection (C) no later than 10 days from the date the applicant or member knows of the change;
4. To send to the Department any medical support received through a Title IV-D court order;
5. To cooperate with assignment of rights and securing payments received from any liable party for a member's medical care.

G. The applicant or member shall provide the following health insurance information, if applicable, at the initial interview and at any review:
1. Name of policyholder,
2. Policyholder's relationship to the applicant,
3. SSN of the policy holder,
4. Name and address of the insurance company, and
5. Policy number.

R9-22-1407. ~~**Application**~~ **Withdrawal of 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.~~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 and stating the reason for withdrawal.
B. If an applicant orally requests to withdraw the application, the Department shall document the:
  1. Date of the request,
  2. Name of the applicant for whom the withdrawal applies,
  3. Reason for the withdrawal,
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. The effective date of the withdrawal is the date of the application.
E. If an applicant requests to withdraw an application, the Department shall:
  1. Deny the application, and
  2. Notify the applicant of the denial following the notice requirements under R9-22-1411.

R9-22-1408. ~~Applicant and Recipient Responsibility~~ Eligibility Interview or Home Visit
~~**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.~~
A. Scheduling an interview or home visit.
  1. Upon receipt of an application, the Department shall:
    a. Schedule an initial eligibility interview or home visit at the request of a homebound applicant or if the Department believes that a home visit may avoid an eligibility error, and
    b. Provide the applicant a written notice of the scheduled interview;

2. The Department shall not require a separate interview unless the application received does not include sufficient information to determine eligibility under this Article for an applicant whose application is received from:
   a. A Baby Arizona provider,
   b. A KidsCare office,
   c. A CRS office, or
   d. Another agency or entity approved by the Administration,

B. Attend the interview. As a condition of eligibility, the applicant or the applicant's representative shall attend the interview.

C. Department's requirement at interview. During the initial interview or review, a Department representative shall:
1. Offer to help the applicant or member to complete the application form and to obtain required verification;
2. Provide the applicant or member with information explaining:
   a. The eligibility and verification requirements of AHCCCS medical coverage;
   b. The requirement that the applicant or member 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 and member's rights and responsibilities, including the right to appeal an adverse action;
   f. The assignment of rights under operation of law as provided in A.R.S. § 36-2903,
   g. That the Department will use information to complete data matches with potential liable parties;
   h. The eligibility review process;
   i. The program coverage and the types of services available under each program;
   j. The family planning services available through AHCCCS health plans if appropriate;
   k. The AHCCCS pre-enrollment process;
   l. Availability of continued AHCCCS medical coverage under R9-22-1420, and
   m. That the Department shall help the applicant or member obtain necessary verification if the applicant or member asks for help.
   3. Review the penalties for perjury and fraud printed on the application;
4. Explain whose income is counted;
5. Review any verification information provided by the applicant or member and give a written list of additional verification items and timeframes that the applicant or member shall provide to the Department;
6. Explain the applicant and member's responsibilities under R9-22-1406; and
7. Review all reporting requirements and explain that the applicant or member may lose the earned income disregards defined in R9-22-1419, if the applicant or member fails to report changes timely; and
8. Explain the MED program under R9-22-1427 through R9-22-1432.

R9-22-1409. ~~Death of an Applicant~~ Withdrawal from AHCCCS Medical Coverage

~~**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.~~

A. A member may withdraw from AHCCCS medical coverage at any time by making an oral or written request for withdrawal to the Department. The member or the member's legal or authorized representative shall provide the Department with:
1. The reason for the withdrawal,
2. The date the request is effective, and
3. The name of the member for whom AHCCCS medical coverage is being withdrawn.

B. The Department shall discontinue eligibility for AHCCCS medical coverage for all family members if the request to withdraw does not identify a specific person.

R9-22-1410. ~~Withdrawal of Application~~ Verification of Eligibility Information

~~**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.~~

A. The applicant or member has the primary responsibility to provide the Department with information necessary to verify eligibility and complete the determination of eligibility at the time of initial application, at a time when change in circumstances occurs which may affect eligibility, or at the eligibility review. With the exception of subsection (B), verification of information shall be obtained using the following types of documents in the following order:

1. First, documented verification which is written evidence originating from an agency, organization, or an individual qualified to have knowledge of the required information;
2. Second, collateral contact which is a verbal statement from an agency, organization, or individual qualified to have knowledge of the required information, or
3. Third, applicant's statement which shall only be used if:
   a. Documented,
   b. Collateral verification is not available, and
   c. The statement is not inconsistent or contracted with other information.

B. Documented verification is the only acceptable form of verification which can be accepted for:

1. SSN,
2. Alien status,
3. Relationship when questionable, and
4. Citizenship when questionable.

C. The Department shall provide an applicant or member no less than 10 days from the date of a written request for the information to provide required verification. The Department may deny the application or discontinue eligibility if an applicant or member does not provide the required information timely.

R9-22-1411. ~~Initial Eligibility Interview~~ Time-frames, Approval, or Denial of the Application

~~**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.~~

A. Application processing time. The Department shall complete an eligibility determination under 42 CFR 435.911 within 45 days after the application date under R9-22-1405; unless:

1. The applicant is pregnant. The Department shall determine eligibility for a pregnant woman within 20 days after the application date unless additional information is required to determine eligibility, or
2. The applicant is in a hospital as an inpatient at the time of application. Within seven days of the Department's receipt of a signed application the Department shall:
   a. Complete an eligibility interview and ask all of the questions on the application, and
   b. Complete an eligibility determination if the Department does not need additional information or verification.

B. Approval. If the applicant meets all the eligibility requirements and conditions of eligibility of this Article, the Department shall approve the application and provide the applicant an approval notice. The approval notice shall contain:

1. The name of each approved applicant,
2. The effective date of eligibility defined in R9-22-1414 for each approved applicant,
3. The supporting reason and the legal citations if a member is approved for only emergency medical services, and
4. The applicant's or member's appeal rights.

C. Denial. If an applicant fails to meet the eligibility requirements or conditions of eligibility of this Article, the Department shall deny the application and provide the applicant a denial notice. The denial notice shall contain:

1. The name of each ineligible applicant;
2. The specific reason why the applicant is ineligible;
3. The income and the resource calculations compared to the income or resource standards when the reason for the denial is due to the applicant's income or resources exceeding the applicable standard;
4. The legal citations supporting the reason for the ineligibility;
5. The location where the applicant can review the legal citations,
6. The month of ineligibility; and
7. The applicant's right to appeal the decision and request a hearing.

R9-22-1412. ~~Withdrawal from the Medical Assistance Program~~ Review of Eligibility

~~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.~~

A. Except as provided in subsection (B), the Department shall complete a review of each member's continued eligibility for AHCCCS medical coverage at least once every 12 months.

B. The Department shall complete a review of eligibility for a:

1. Pregnant woman following the termination of her pregnancy,
2. Non-pregnant member approved only for emergency medical services at least once in a three-month period or following the end of the emergency episode whichever comes first,
3. Member approved for the MED program under R9-22-1427 through R9-22-1432 prior to the end of the six-month eligibility period, or
4. Any time there is a change in a member's circumstance which may affect eligibility.

C. If a member continues to meet all eligibility requirements and conditions of eligibility, the Department shall authorize continued eligibility and notify the member of continued eligibility.

D. The Department shall discontinue eligibility and shall notify the member of the discontinuance under R9-22-1413 if the member:

1. Fails to comply with the review of eligibility,
2. Fails to comply with the requirements and conditions of eligibility under this Article without good cause under 42 CFR 433.148, or
3. Does not meet the eligibility requirements.

R9-22-1413. ~~Verification of Eligibility Information~~ Notice of Discontinuance Action

~~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.~~

A. Notice requirement. If a member fails to meet an eligibility requirement or condition of eligibility, the Department shall provide the member an advance Notice of Action for an adverse action no later than 10 days before the effective date of the discontinuance.

B. The Department may mail an adverse Notice of Action no later than the effective date of the discontinuance if the Department:
   1. Receives a request to withdraw under R9-22-1409,
   2. Receives verification that the member is ineligible under R9-22-1402,
   3. Has documented information confirming the death of a member,
   4. Receives returned mail with no forwarding address from the post office and the member's whereabouts are unknown; or
   5. Verifies that the member has been approved for Medicaid by another state.

C. The notice shall contain:
   1. The name of each ineligible member;
   2. The specific reason why the member is ineligible;
   3. The income and the resource calculations compared to the income or resource standards when the reason for the discontinuance is due to the member's income or resources exceeding the applicable standard;
   4. The legal citations supporting the reason for the ineligibility;
   5. The location where the member can review the legal citations,
   6. The date the discontinuance is effective, and
   7. The member's appeal rights and right to continued medical coverage pending appeal.

R9-22-1414. ~~Processing the Application - Approvals and Denials~~ Effective Date of Eligibility

Except for the MED program under R9-22-1427 through R9-22-1432 and eligibility for a newborn under R9-22-1422, the effective date of eligibility is the first day of the month that the applicant files an application if the applicant is eligible that month, or the first day of the first eligible month following the application month.

~~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.~~

Effective Date of Eligibility

Except for the MED program under R9-22-1427 through R9-22-1432 and eligibility for a newborn under R9-22-1422, the effective date of eligibility is the first day of the month that the applicant files an application if the applicant is eligible that month, or the first day of the first eligible month following the application month.

R9-22-1415. ~~Review~~ Operation of Law

~~**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.~~

A person determined eligible assigns rights to all types of medical benefits to which the person is entitled under operation of law under A.R.S. § 36-2903.

R9-22-1416. ~~Notice of Termination Action~~ Social Security Number

~~**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.~~

As a condition of eligibility, an applicant shall furnish a SSN, under 42 CFR 435.910 and 435.920. A person who cannot legally obtain a SSN is not required to furnish a SSN. An applicant has until the first review to provide a SSN as long as the applicant is cooperating with the Department to obtain a SSN. If an applicant cannot recall or has not been issued a SSN, the Department shall assist in obtaining or verifying the applicant's SSN under 42 CFR 435.910.

R9-22-1417. ~~Reinstatement of Medical Assistance~~ State Residency

~~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.~~

As a condition of eligibility, an applicant or member shall be a resident of Arizona under 42 CFR 435.403.

R9-22-1418. ~~Dependent Child Living with Specified Relative~~ Citizenship and Immigrant Status

~~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.~~

A. As a condition of eligibility for full services under Article 2, an applicant or member shall be a citizen of the United States, or shall meet requirements for qualified alien under A.R.S. §§ 36-2903.03(A) and 36-2903.03(B), or A.R.S. § 36-2903.03(C).

B. An applicant is eligible for emergency medical services defined in R9-22-217 when the applicant is either a qualified alien or noncitizen:
1. Meets all other eligibility requirements, except those in subsection (A), and
2. Is eligible under A.R.S. § 36-2901(6)(a)(i), (ii), or (iii).

R9-22-1419. ~~Assistance Unit~~ Income Eligibility Criteria

~~**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.~~

A. Evaluation of income. In determining eligibility, the Department shall evaluate the following types of income received by a person identified in subsection (B):
1. 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.

B. A person whose income is counted. The Department shall include the income of the following persons when living together under Section 1902(a)(17) of the Act:
1. Applicant;
2. Applicant's parent, if the applicant is an unmarried minor child,
3. Applicant's spouse;
4. The sponsor and sponsor's spouse of a person meeting the alien requirements under A.R.S. § 36-2903.03;
5. If applying as a family under R9-22-1420 which includes a dependent child, living with a specified relative, the non-parent caretaker relative and spouse, as allowed under R9-22-1420, and their unmarried minor children;
6. The Department shall not include the income of a SSI cash recipient.

C. Income exclusions. The Department shall exclude the following income:
1. Agent Orange settlement fund payments;
2. AmeriCorps Network Program;
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 funded by the United States Department of Education or from Veterans Education assistance program or the Bureau of Indian Affairs student assistance program;
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. Fair Labor Standard Act supplemental payment;
11. Food stamp benefits;
12. Foster care maintenance payments intended for children who are not included in the family or MED unit;
13. Funds set aside in an Individual Development Account under A.A.C. R6-12-404;
14. Governmental rent and housing subsidies;
15. Income tax refunds, including any earned income tax credit;
16. Loans from a private person, a commercial or educational institution;
17. Nonrecurring cash gifts which do not exceed $30 per person in any calendar quarter;
18 Payments made from fund established by the Susan Walker v. Bayer Corporation class action lawsuit or the Ricky Ray Hemophilia Relief Fund Act of 1998;
19. Radiation exposure compensation payments;

20. Reimbursement for work-related expenses which do not exceed the actual expense amount;
21. Reimbursement for Job Opportunities and Basic Skills (JOBS) Program training-related expenses;
22. Reparation and restitution payments under Section 1902(r) of the Act;
23. SSI Designated account and interest earned on that account;
24. TANF or SSI cash assistance payment;
25. Vendor payment to a third-party vendor to cover family expenses, provided the payment is made by an organization or a person who is not a member of the family or MED unit;
26. Volunteers In Service To America (VISTA) income which does not exceed the state or federal minimum wage;
27. Vocational rehabilitation program payments made as reimbursement for training-related expenses, subsistence and maintenance allowances, and incentive payments which are not intended as wages;
28. Women, Infants, and Children (WIC) benefits; or
29. Any other income specifically excluded by applicable federal law under 20 CFR Part 416 Appendix K.

D. Special income provision for child support. The Department shall consider child support to be income of the child for whom the support is intended and count the child support income received after deducting $50 per child.

E. Determining Income For a Month
1. The Department shall include income which is received during the month or which the person reasonably expects to receive in the month based on reasonable expectations and knowledge of the person's current, past, and anticipated future circumstances.
2. The Department shall deduct the applicable disregards and deductions to which a person is entitled for the month.
3. The Department shall convert income received more frequently than monthly to a monthly amount.
4. The Department shall consider a one time lump sum income in the month the income is received.

F. Earned Income Disregards.
1. General. The Department shall apply the earned income disregards to each employed person's gross earnings.
2. Disregards. The Department shall apply the following method to calculate the amount of the countable earned income:
   a. Subtract a $90 cost of employment (COE) allowance from the gross amount of earned income for each person whose earned income is counted;
   b. Subtract an amount billed by the child care provider for the care of each dependent child or incapacitated adult member who is the responsibility of the person whose income shall be counted for the purposes to allow the person to work, not to exceed:
      i. For a wage-earner employed full-time (86 hours or more a month), $200 for a child under age two, and $175 for the other dependents; and
      ii. For a wage earner employed part-time (less than 86 hours a month), $100 for a child under age two, and $88 for the other dependents.
3. Loss of disregards. The Department shall not apply the earned income disregards, if the member fails to report to the Department a change in income within 10 days from the date the change becomes known to the member. The change report to the Department shall be postmarked no later than the 10th day from the date the change becomes known.

R9-22-1420. ~~Deprivation~~ Eligibility For a Family

~~**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~~

~~c. 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.~~

A. The Department shall determine eligibility for AHCCCS medical coverage for a family unit when the requirements under this Section are met.

B. The family unit shall include the following when living together:

1. A natural or adopted dependent child under age 18,
2. A dependent child age 18, who is:
   a. A full-time student at a secondary school; or
   b. Attending a vocational or technical training school which includes shop practicum for at least 30 hours per week or does not include shop practicum and attendance is at least 25 hours per week; and
   c. Reasonably expected to complete the education or training before age 19; and

3. A natural or adoptive parent of a dependent child.
4. An unborn child of a person in the family unit.

C. The Department shall include the spouse of the dependent child's parent if the spouse wants to apply for AHCCCS medical coverage.

D. The Department shall include the dependent child's non-parent caretaker relative and the spouse of the non-parent caretaker relative, if the non-parent caretaker relative wants to apply for AHCCCS medical coverage and:

1. Provides a dependent child with:
   a. Physical care,
   b. Support,
   c. Guidance, and
   d. Control; and
2. The parent of a dependent child:
   a. Does not live in the non-parent caretaker relative's home;
   b. Lives with the non-parent caretaker relative but is also a dependent child; or
   c. Lives with the non-parent caretaker relative but cannot function as a parent due to physical or mental impairment.
3. The Department shall not include a SSI-cash recipient in the family unit.

E. Income standard. The family unit's countable income shall not exceed 100 percent FPL adjusted annually based on the number of persons in the family unit.

F. Continued medical coverage. An eligible member of the family unit under this Section may be entitled to continued AHCCCS coverage for up to 24 months if eligible under subsection (3)(a) and up to four months if eligible under subsection (3)(b) if the family unit's income exceeds the 100 percent FPL and the following conditions are met:

1. The family continues to include a dependent child,
2. The family received AHCCCS medical coverage for three calendar months out of the most recent six months, and
3. The loss of AHCCCS coverage is due to:
   a. Increased earned income of the caretaker relative and the person is a member of the family unit in accordance with 42 U.S.C.1396a(e)(1) and 42 U.S.C.1396r-6, or
   b. Increased spousal or child support and the family unit member meets requirements under 42 CFR 435.115(f) and Section 1931(c) of the Act.

R9-22-1421 ~~Application for Other Benefits~~ Eligibility For A Person Not Eligible As A Family

~~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.~~

Income standards. A person who is not approved in a family unit under R9-22-1420 but meets all the eligibility requirements in the Article is eligible for AHCCCS medical coverage if income does not exceed the following FPL levels adjusted annually:

A. 140 percent for a pregnant woman or a child under one year of age,

B. 133 percent for a child age one through five years of age, or

C. 100 percent for all other persons.

R9-22-1422. ~~Assignment of Rights; Cooperation~~ Eligibility For a Newborn

~~**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.~~

A child born to a mother eligible and receiving medical coverage under this Article, Article 15, and 9 A.A.C. 22, is automatically eligible for AHCCCS medical coverage for a period not to exceed 12 months if the child continuously lives with the mother in the state of Arizona. Eligibility begins on the child's date of birth and ends with the last day of the month in which the child turns age one. The Department shall conduct an informal review at six months to ensure the child resides with the mother in Arizona.

R9-22-1423. ~~Social Security Number~~ Extended Medical Coverage For A Pregnant Woman

~~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.~~
A. A pregnant woman who applies for and is determined eligible for AHCCCS medical coverage 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.

R9-22-1424. ~~State Residency~~ Family Planning Services Extension Program

~~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.~~
A. Except as under 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 for any of the following reasons:
1. Voluntary withdrawal,
2. Loss of contact,

3. Failure to provide information,
4. Incarceration,
5. Move out-of-state
6. Sterility, or
7. Death.

R9-22-1425. ~~Citizenship and Alien Status~~ Young Adult Transitional Insurance

~~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.~~

A person under the age of 21 who was in foster care under the responsibility of the state on their 18th birthday is eligible for AHCCCS medical coverage under § 36-2901.6(a)(iii).

R9-22-1426. ~~Resources~~ Special Groups For Children

~~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.~~

The Administration shall provide AHCCCS medical coverage to children eligible for Title IV-E adoption subsidy or Title IV-E foster care under 42 CFR 435.145 and children eligible for state adoption subsidy under 42 CFR 435.227.

R9-22-1427. ~~Determining Resource Eligibility~~ Eligibility For a Person With Medical Bills Whose Income is Over 100 percent FPL

~~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.~~

An applicant who is not eligible for AHCCCS medical coverage due to excess income may become AHCCCS eligible by deducting medical expenses from their income. This coverage is called Medical Expense Deduction (MED).

R9-22-1428. ~~Income~~ MED Family Unit

~~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.~~

A. For the purpose of this subsection, a child is an unmarried person under age 18.
B. The Department shall consider each of the following to be a family when living together:
1. A parent and that parent's minor children,
2. A married couple without minor children,
3. A married couple and the minor children of either or both spouses,
4. Unmarried parents who live with minor children in common, and their minor children, whether in common or not, or
5. A person without children.

C. If an applicant is pregnant, the family unit shall be increased by the number of unborn.
D. When a child in the MED family unit is a parent of children, who live with that child, the Department shall include the child's children in the family.
E. The Department shall not include a SSI-cash recipient in the MED family unit even if a SSI-cash recipient is a parent, spouse or child.

R9-22-1429. ~~Earned Income Disregards~~ MED Income Eligibility Requirements

~~**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~~

A. Income exclusions. The exclusions in R9-22-1419(C) apply to the MED family unit.

B. Income standard.
1. The Department shall divide the annual FPL for the MED family unit that is in effect during each month of the income period by 12 to determine the monthly FPL.
2. The Department shall add the monthly FPLs for the income period and multiply the resulting amount by 40 percent.
3. Changes made to the annual FPL will be made effective in April each year.

C. Income period. The income period is the month of application and the next two months. The Department shall add together the three months' income to establish the MED family unit's income amount.

D. Medical expense deduction period. The medical expense deduction period is a three month period consisting of the month before the application month, the month of application, and month following the application month.

E. The Department shall calculate the amount of countable monthly income as follows:
1. Subtract a $90 cost of employment allowance from the gross amount of earned income for each person whose earned income is counted,
2. Subtract from the remaining earned income an amount billed by the child care provider for the care of each dependent child under age 18 or incapacitated adult member of the MED family unit for the purposes to allow the person to work, not to exceed:
   a. $200 for a child under age two and $175 for the other dependents for a wage-earner employed full-time (86 or more hours per month); and
   b. $100 for a child under age two, and $88 for the other dependents for a wage earner employed part-time (less than 86 hours a month);
3. Add the remaining earned income for each MED family member to the unearned income of all MED family members;
4. Compare the MED family's unit countable income amount to the income standard in subsection (B). The difference is the amount of medical expenses the family shall incur during the medical expense deduction period to become eligible;
5. Subtract allowable medical expense deductions which were incurred by:
   a. A member of the MED family unit;
   b. A deceased spouse or minor child of a MED family unit if this person would have been a member of the MED unit during the MED expense deduction period;
   c. A person who was a minor child of a MED family unit member when the expense was incurred but who is no longer a minor child; or
   d. A minor child who left home prior to the date of application to live with someone other than a parent. This includes a child who is a runaway;
6. Compare the net MED family income to the income standard listed in subsection (B); and
7. Family is eligible if the net income in subsection (6) does not exceed the income standard in subsection (B).

R9-22-1430. ~~Determining Income Eligibility~~ MED Resource Eligibility Requirements

~~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. or 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.~~

A. Include countable resources. The Department shall include the countable resources belonging to and available to members of the family, and sponsor and sponsor's spouse of a person who is a qualified alien under A.R.S. § 36-2903.03.

B. Ownership and availability. The Department shall evaluate the ownership of resources to determine the availability of resources to a person listed in subsection (A).

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 one of the owners refuses to sell. A consent to sale is not required if all owners are members of the MED family unit.
2. Jointly owned resources, with ownership records containing the word "or" between the owners' names, are presumed to be available in full to each owner. The applicant or member may rebut the presumption by providing clear and convincing evidence of intent to establish a different type of ownership. If the presumption is rebutted, the resource is available to the owners:
   a. Consistent with the intent of the owners, or
   b. Based on each owner's proportionate net contribution if there is not clear and convincing evidence of a different allocation.
3. The availability of a trust shall be established under 42 U.S.C. 1396p(d)(4)(A) or (C).

C. Unavailability. The Department shall consider the following resources unavailable:

1. Property subject to spendthrift restriction which may include:
   a. 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 MED family unit; or
   b. Trusts established by a will or funded solely by the income and resources of someone other than a member of the MED family unit.
2. A resource being disputed in divorce proceedings or in probate matters;
3. Real property located on a Native American reservation;
4. A resource held by a conservator are unavailable to the extent court imposed restrictions make the resource unavailable to the applicant, member, or member of the family unit for:
   a. Medical care,
   b. Food,
   c. Clothing, or
   d. Shelter.

D. Resource exclusion. The Department shall exclude the following resources:

1. One burial plot for each person listed in R9-22-1428;
2. Household furnishings and personal items which are necessary for day-to-day living;

3. Up to $1500 of the value of one prepaid funeral plan, for each person listed in R9-22-1428, that specifically covers only funeral-related expenses as evidenced by a written contract;
4. The value of one motor vehicle regularly used for transportation. If the MED family unit owns more than one vehicle, the exclusion is applied to the vehicle with the highest equity value. The equity value of all remaining vehicles is counted toward the resource standard in subsection (F), subject to the limitations described in this Section;
5. A vehicle used to earn income and not simply transportation to and from employment;
6. The value of any vehicle in which the SSI-cash recipient has an ownership interest;
7. The value of any vehicle used for medical treatment, employment, or transportation of a SSI-cash disabled child, and which is excluded by SSI for that reason;
8. Funds set aside in an Individual Development Account under 6 A.A.C.12 Article 4; and
9. Any other resource specifically excluded by federal law.

E. Calculation of resources. The Department shall determine the value of all household resources as follows:
1. Calculate the total amount of the liquid resources;
2. Calculate the equity value of each non-liquid resource. The Department shall determine the equity value of a non-liquid resource by subtracting the amount of valid encumbrances on that resource from:
   a. The market value of real property if the assessor's value of real property does not include the value of permanent structures on that property, or there is no assessor's evaluation of the property;
   b. The assessor's full cash value as the value of all other real property,
   c. The market value of all other nonliquid resources; and
   d. The equity value of a resource shall not be less than zero.
3. Determine the MED family unit's resources by adding the totals determined in subsections (1) and (2).

F. Resource standard. The resources determined in subsection (E) shall not exceed $100,000 of which no more than $5,000 shall be liquid assets.

R9-22-1431. ~~**Effective Date of Eligibility**~~ **MED 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.~~

A. The MED family unit is eligible on the day the income and resource eligibility requirements are met but no earlier than the first day of the month of application. If the family unit meets the income criteria in the application month but does not meet the resource limit until the following month, the family unit's effective date of eligibility is the first day of the month following the month of application.

B. The Department shall adjust the effective date of eligibility to an earlier date if:
1. A member presents verification of additional allowable medical expenses incurred on an earlier date during the medical expense deduction period, and
2. A member presents the verification within 60 days of the approval of eligibility under this Section.

C. The Department shall not adjust an effective date of eligibility more than one time per application.

D. The Department shall adjust the effective date no later than 30 days after the end of the 60 day period.

E. The Department shall deny the application and provide the applicant a denial notice when an applicant does not meet the MED requirements under this Article during the month of application or the month following the month of application.

R9-22-1432. ~~**Prior Quarter Eligibility**~~ **MED Eligibility Period**

~~**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.~~

Eligibility shall be approved for six months with changes in circumstances not affecting eligibility for the first three months.

R9-22-1433. ~~**Deemed Newborn Eligibility**~~ **Eligibility Appeals**

~~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.~~

A. Adverse actions. An applicant or member 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 AHCCCS medical coverage; or
3. Delay in the eligibility determination beyond the timeframes under this Article.

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. An applicant or a member is 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. An applicant or member may request a hearing from the Department. The Department shall conduct the hearing in accordance with the Department's appeal procedures under A.A.C. R6-12-1002, R6-12-1003, and R6-12-1005 through R6-12-1013. For purposes of this Section, any references in the Department's rules to the word "benefits" shall refer to AHCCCS medical coverage, any reference to the cash assistance program shall refer to the AHCCCS medical coverage, and references to cash overpayments are not applicable.
E. Stay of adverse action pending appeal and exceptions.
1. If an appellant files a request for appeal within 10 days after the date of the Notice of Action, the Department shall not impose the adverse action and shall continue AHCCCS medical coverage 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. If the agency mails the notice as required under R9-22-1411 and R9-22-1413 and the member does not request a hearing before the date of action,
   b. 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;
   c. A change in eligibility occurs for a reason other than the issue on appeal, and the member receives and fails to timely appeal a Notice of Action concerning the change;
   d. Federal or state law mandates an automatic adjustment for classes of recipients;
   e. The appellant withdraws the request for hearing; or
   f. 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 AHCCCS medical coverage has been continued may be financially liable for all AHCCCS medical coverage received during a period of ineligibility if the Department finds in favor of 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 finds in favor of the appellant, eligibility is retroactive to the date of discontinuance or the first day the person would have otherwise been eligible under this Article.
G. Further Appeal and Review of Hearing Decisions.
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.
3. The parties may seek judicial review of the final written decision of the Appeals Board under Title 41, Chapter 14, Article 3, Arizona Revised Statutes. The Appeals Board's final decision shall identify the appellant's right to seek judicial review.

R9-22-1434. ~~Extended Medical Assistance Coverage for a Pregnant Woman~~ Repealed

~~**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.~~

R9-22-1435. ~~Family Planning Services Extension Program~~ Repealed

~~**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.~~

R9-22-1436. ~~Eligibility Appeals~~ Repealed

~~**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.~~

ARTICLE 15. ~~SSI MAO ELIGIBILITY~~ AHCCCS MEDICAL COVERAGE FOR PEOPLE WHO ARE AGED, BLIND, OR DISABLED

R9-22-1501. ~~SSI Medical Assistance Only (MAO) Coverage Groups~~ General Information

~~**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.~~

A. General. The Administration shall determine eligibility for AHCCCS medical coverage for the following applicants or members using the eligibility criteria and requirements in this Article.

1. A person who is aged, blind, or disabled and does not receive SSI cash under 42 CFR 435.210.
2. A person terminated from the SSI cash program and under R9-22-1505.

B. Confidentiality. The Administration shall maintain the confidentiality of the person's records and shall not disclose the person's financial, medical, or other confidential information except under Article 5.

C. Application Process.
1. A person may apply for AHCCCS medical coverage by submitting a signed application to any Administration office or outstation location under R9-22-1405.
2. The applicant, a minor applicant's parent, the applicant's legal or authorized representative, or if the applicant is incompetent or incapacitated, someone acting responsibly on behalf of the applicant may file the application. An application shall be witnessed and signed by a third party if an applicant signs an application with a mark.
3. The application date is the date a signed application is received at any Administration office or outstation location.
4. The applicant who files an application may withdraw the application, either orally or in writing. If an applicant withdraws an application, the Administration shall send the applicant a denial notice under subsection (F).
5. Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 90 days for an applicant applying on the basis of disability and 45 days for all other applicants.
6. If an applicant dies while an application is pending, the Administration shall complete an eligibility determination for the deceased applicant.
7. The Administration shall complete an eligibility determination on an application filed on behalf of a deceased applicant, if the application is filed in the month of the person's death.

D. Redetermination of eligibility for a person terminated from SSI cash program.
1. Continuation of AHCCCS medical coverage. The Administration shall continue AHCCCS medical coverage for a person terminated from SSI cash program until a redetermination of eligibility under subsection (2) is completed.
2. Coverage group screening. The Administration shall screen for eligibility under any coverage group under A.R.S. §§ 36-29016)(a)(i) and (ii) 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 or member is aged, blind, or disabled, but not in need of long-term care services, the Administration shall determine eligibility under this Article.
   c. For all other persons, the Administration shall refer the case to the Department for an eligibility decision under Article 14.
3. Eligibility decision.
   a. If the applicant is eligible under this Article or 9 A.A.C. 28, Article 4, the Administration shall send a notice as under subsection (F) informing the applicant that AHCCCS medical coverage shall continue.
   b. If the applicant is ineligible, the Administration shall send a notice as under subsection (F) to discontinue AHCCCS medical coverage.

E. Eligibility effective date. Eligibility shall be effective on the first day of the month that all eligibility requirements are met, but no earlier than the month of application.

F. Notice for Approval or Denial. The Administration shall send an applicant a written notice of the decision regarding the application. This notice shall include a statement of the intended action, and:
1. If approved, the notice shall contain the effective date of eligibility.
2. If approved under FESP, the notice shall also contain:
   a. The emergency services certification end date;
   b. A statement detailing the reason for the denial of full services;
   c. The legal authority supporting the decision;
   d. Where the legal authority supporting the decision can be found;
   e. An explanation of the right to request a hearing; and
   f. The date by which a request for hearing shall be received by the Administration.
3. If denied, the notice shall contain:
   a. The effective date of the denial;
   b. The reason for the denial, including specific financial calculations and the financial eligibility standard if applicable;
   c. Legal authority supporting the decision;
   d. Where the legal authority supporting the decision can be found;
   e. An explanation of the right to request a hearing; and
   f. The date by which a request for hearing shall be received by the Administration.

G. Reporting and verifying changes.
1. Under 42 CFR 435.916, a member shall report to the Administration the following changes for an applicant or a member, an applicant or member's spouse, and an applicant or member's dependent children:
   a. Change of address;
   b. Change in the household's members;
   c. Change in income;

d. Change in resources, when applicable;
e. Determination of eligibility for other coverage;
f. Death;
g. Change in marital status;
h. Change in school attendance;
i. Change in Arizona state residency; and
j. Any other change that may affect the member or applicant's eligibility.

2. Under 42 CFR 435.916, a member shall report to the Administration the following changes for an applicant or a member:
   a. Admission to a penal institution,
   b. Change in U.S. citizenship or immigrant status,
   c. Receipt of a Social Security Number, and
   d. Change in first- or third-party liability which may contribute to the payment of all or a portion of the person's medical costs.
3. A person may report a change either orally or in writing and shall include the:
   a. Name of the affected applicant or member;
   b. Description of the change;
   c. Date the change occurred;
   d. Name of the person reporting the change; and
   e. Social Security or case number of the applicant or member, if known.
4. A person shall provide verification of changes upon request of the Administration.
5. A person shall report anticipated changes in eligibility as soon as the future event becomes known.
6. A person shall report an unanticipated change within 10 days following the date the change occurred.

H. Processing of changes and redeterminations. If a person receives AHCCCS medical coverage under subsection (A), the member's eligibility shall be redetermined at least once every 12 months or more frequently when changes occur under 42 CFR 435.916 which may affect eligibility.

I. Actions that may result from a redetermination or change. The processing of a redetermination or change shall result in one of the following actions:
1. No change in eligibility,
2. Discontinuance of eligibility if a condition of eligibility is no longer met, or
3. A change in the program under which a person receives AHCCCS medical coverage.

J. Notice of Discontinuance.
1. Contents of notice. The Administration shall issue a notice whenever it takes an action to discontinue a member's eligibility. The 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 discontinuance, including specific financial calculations and the financial eligibility standard if applicable;
   d. The legal authority that supports the action proposed by the Administration;
   e. Where the legal authority supporting the decision can be found;
   f. An explanation of the right to request a hearing; and
   g. The date by which a hearing request shall be received by the Administration and the right to continue medical coverage pending appeal.
2. Advance notice of changes in eligibility. Advance notice means a notice of proposed action that is issued to the member at least 10 days before the effective date of the proposed action. Except under subsection (3), advance notice shall be issued whenever an adverse action is taken to discontinue eligibility.
3. Exceptions from advance notice. Under 42 CFR 431.213, a notice shall be issued to the member to discontinue eligibility no later than the effective date of action if:
   a. A member provides a clearly written statement, signed by that member, that:
      i. Services are no longer wanted; or
      ii. Gives information that requires termination or reduction of services and indicates that the member understands that this shall be the result of supplying that information;
   b. A member provides information that requires termination of eligibility and a member signs a written statement waiving advance notice;
   c. A member cannot be located and mail sent to the member's last known address has been returned as undeliverable subject to reinstatement of discontinued services under 42 CFR 231(d);
   d. A member has been admitted to a public institution where a person is ineligible for coverage;
   e. A member has been approved for Medicaid in another state; or
   f. The Administration receives information confirming the death of a member.

K. Request For Hearing. An applicant or member may request a hearing under Article 8 for any of the following adverse actions:
1. Complete or partial denial of eligibility;
2. Termination or reduction of AHCCCS medical coverage; or
3. Delay in the eligibility determination beyond the timeframes listed in R9-22-1501(C).

L. Assignment of Rights. A person determined eligible assigns rights to all types of medical benefits to which the person is entitled under operation of law under A.R.S. § 36-2903.

M. Title VI Compliance. The Administration shall determine eligibility under the provisions of this Article. The Administration 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 U.S.C., Section 2000d, and rules and regulations promulgated according to, or as otherwise provided by law.

R9-22-1502. ~~Eligibility Determination Process~~ General Eligibility Criteria

~~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 time-frames 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.~~

A. Social Security Number.
1. An applicant applying under R9-22-1501(A)(1), (A)(2), and R9-22-1505(A) shall furnish a SSN or apply for one, under 42 CFR 435.910 and 435.920.
2. An applicant who meets all other eligibility criteria except those in subsection (C) shall provide a SSN unless the applicant cannot legally obtain one.
3. If an applicant cannot recall or has not been issued a SSN, the Administration shall assist in obtaining or verifying the applicant's SSN under 42 CFR 435.910.

B. State Residency.
As a condition of eligibility, a person shall be a resident of Arizona under 42 CFR 435.403.

C. Citizenship and Immigrant Status.
1. As a condition of eligibility for full services under Article 2, an applicant or member shall be a citizen of the United States, or shall meet requirements for qualified alien under A.R.S. §§ 36-2903.03(A) and 36-2903.03(B), or A.R.S. § 36-2903.03(C).
2. An applicant is eligible for emergency medical services defined in R9-22-217 when the applicant is either a qualified alien or noncitizen:
   a. Meets all other eligibility requirements, except those in subsection (1), and
   b. Is eligible under A.R.S. §§ 36-2901(6)(a)(i), 36-2901(6)(a)(ii), or 36-2901(6)(a)(iii).

D. Applicant and Member Responsibility. As a condition of eligibility, an applicant and member shall:
1. An applicant and member shall authorize the Administration to obtain verification.
2. As a condition of eligibility, an applicant and member shall:
3. Give the Administration complete and truthful information. The Administration may deny an application or discontinue eligibility if:
   a. The applicant or member fails to provide information necessary for initial or continuing eligibility,
   b. The applicant or member fails to provide the Administration with written authorization to permit the Administration to obtain necessary verification,
   c. The applicant or member fails to provide verification after the Administration had made an effort to obtain the necessary verification but has not obtained the necessary information, or
   d. The applicant or member does not assist the Administration in resolving incomplete, inconsistent, or unclear information that is necessary for initial or continuing eligibility.
4. Comply with the DCSE under 42 CFR 433.148 in establishing paternity and enforcing medical support obligations when requested. The Administration shall not deny AHCCCS eligibility to any applicant who would otherwise be eligible and who is a minor child and whose parent or legal representative does not cooperate with the medical support requirements or first-and third-party liability under Article 10;
5. Provide information concerning third-party coverage for medical care;
6. Take all necessary steps to obtain annuity, pension, retirement, and disability benefits for which an applicant or member may be entitled.

E. Inmate of a public institution. An inmate of a public institution is not eligible for AHCCCS coverage if federal financial participation (FFP) is not available.

F. Verification of eligibility information.
1. The applicant or member has the primary responsibility to provide the Administration with verification for all information necessary to complete the determination of eligibility.
2. The Administration shall provide an applicant or member no less than 10 days following the date of written request for the information to provide required verification. If an applicant or member does not provide the required information timely, the Administration may deny the application or discontinue eligibility.

~~R9-22-1503.~~ ~~State Residency~~ Financial Eligibility Criteria

~~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.~~

A. General income eligibility. The Administration shall count the income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K with the following exceptions in (B).

B. Exceptions.
1. In-kind support and maintenance is excluded. In-kind support and maintenance is explained in 42 U.S.C. 1382a(a)(2)(A).
2. 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 coverage under this Article.
3. In determining the net income of a married couple living with a child or of a person who is not living with a spouse but 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 under 20 CFR 416.1163(b)(1) and (2).
4. In determining the income deemed available to an applicant who is a child, from an ineligible parent or parents to an applicant who is a child, an allocation for each eligible or ineligible child of the parent is allowed as a deduction from the parent's income using the methodology under 20 CFR 416.1165(b) and each child's allocation is reduced by that child's income, including public income maintenance payments.

R9-22-1504. ~~Citizenship and Qualified Alien Status~~ Eligibility For A Person Who is Aged, Blind, or Disabled

~~**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).~~

A. To be eligible for AHCCCS medical coverage an applicant shall meet the conditions of eligibility and requirements in this Article and meet one of the income tests described in subsections (B), (C), or the special requirements in R9-22-1505.

B. The Administration shall determine if the applicant's countable income, as described in Section R9-22-1503, is less than or equal to 100 percent of the SSI FBR, adjusted annually.

C. The Administration shall determine if the applicant's countable income, as described in Section R9-22-1503, without deducting the amount from earned income under 42 U.S.C. 1382a(b)(4)(B)(iii), is less than or equal to 100 percent FPL adjusted annually.

R9-22-1505. ~~Social Security Enumeration~~ Eligibility for Special Groups

~~**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.~~

A. Special Groups.

1. A person, meeting the requirements in A.R.S. § 36-2903.03 who:
   a. Is aged, blind, or disabled under 42 CFR 435.520; 42 CFR 435.530; or 42 CFR 435.540;
   b. Received SSI cash or AHCCCS medical coverage under subsections (A)(1) through (A)(4) on or before August 21, 1996;
   c. Was residing in the United States under color of law on or before August 21, 1996; and
   d. Meets the requirements under this Article.
2. A disabled child (DC), under 42 U.S.C. 1396a(a)(10)(A)(i)(II). 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;
   c. Continues to meet the disability requirements for a child which were in effect on August 21, 1996; and
   d. Meets the requirements under this Article.
3. A disabled adult child (DAC), under 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. Meets the requirements under this Article, and
   e. Is 18 years of age or older.
4. A disabled widow or widower (DWW), under 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, and
   d. Meets the requirements under this Article.
5. A person, under 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 one 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. Meets the requirements under this Article.

B. Resource Criteria for Special Groups
1. Except as provided in subsection (2), resource eligibility is determined using the resource criteria in 42 U.S.C. 1382a(3), U.S.C. 1382b, and 20 CFR 416 Subpart L.
2. Exceptions. The value of the following resources is excluded from eligibility determination:
   a. Household goods and personal effects;
   b. Burial Insurance;
   c. Assets that an applicant has irrevocably assigned to fund the expenses of a burial;
   d. The value of all 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;
   e. 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
   f. The value of oil, mineral, and timber rights.
3. 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).

C. Income for Special Groups
1. Except as provided in subsection (2), income eligibility is determined using the income criteria in R9-22-1503(A).
2. Exceptions to income for special groups.
   a. For a person in the DAC coverage group, defined by R9-22-1505(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).
   b. For a person in the DWW coverage group, defined by R9-22-1505(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).
   c. For an applicant or member in the coverage group defined by R9-22-1505(A)(5), the portion of the applicant's or member'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.

D. 100 percent FBR

As a condition of eligibility for all special groups, countable income shall be equal to or less than 100 percent of the SSI FBR, adjusted annually.

R9-22-1506. ~~Resource Criteria for SSI MAO Eligibility~~ Repealed

~~**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).~~

R9-22-1507. ~~Income Criteria for Eligibility~~ Repealed

~~**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.~~

R9-22-1508. ~~Changes and Redeterminations~~ Repealed

~~**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.~~

ARTICLE 16. ~~STATE-ONLY ELIGIBILITY~~ REPEALED

R9-22-1601. ~~Who May Apply for MI/MN Benefits~~ Repealed

~~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).~~

R9-22-1602. ~~**Application for MI/MN Benefits**~~ **Repealed**

~~**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.~~

R9-22-1603. ~~**Priority Applications for MI/MN Eligibility**~~ **Repealed**

~~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.~~

R9-22-1604. ~~**MI/MN Applications for Applicants Facing a Loss of Categorically Eligible Status Due to Termination of SSI Benefits**~~ **Repealed**

~~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.~~

R9-22-1605. ~~Responsibilities of the Head-of-household for MI/ MN Eligibility~~ Repealed

~~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.~~

R9-22-1606. ~~MI/MN Statement of Truth by the Head-of-household~~ Repealed

~~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.~~

R9-22-1607. ~~Notice of Reapplication~~ Repealed

~~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.~~

R9-22-1608. ~~County Responsibility for Completion of MI/MN Eligibility Determination~~ Repealed

~~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 a face-to-face interview when the head-of-household is present at the scheduled appointment time. During the 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 information received is confidential;~~
   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 other 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 or supplements 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 applicant is hospitalized:
a. Outside of the applicant'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 applicant'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 of the information and requirements in the Statement of Truth;
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 before 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. Refer the head-of-household to apply for categorical or Title XXI eligibility if screened as potentially eligible and concurrent application is not required under R9-22-1610.
7. 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.~~

R9-22-1609. ~~MI/MN Timeliness Requirements~~ Repealed

~~**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 or information requested by the county eligibility staff under this Article by the 10th day following the date the county eligibility staff provides the head-of-household a written request for the information. The county eligibility staff shall, upon request by the head-of-household, extend the 10-day time-frame. The county eligibility staff shall not extend the time-frame beyond the 30th day following the date of application, except as specified in subsection (C).~~
~~**C.** Extension of an allotted time. The county eligibility staff shall extend the 30-day time-frame in subsections (A) and (B) 1 time, by 30 days, if the head-of-household requests additional time to obtain or provide verification or information required by the county eligibility staff to determine MI/MN eligibility.~~
~~**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 county eligibility staff shall not extend the 30-day time-frame in subsections (A) and (B) unless the head-of-household agrees in writing to the extension and acknowledges 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.~~

R9-22-1610. ~~Forwarding Applications to Obtain Categorical or Title XIX Eligibility~~ Repealed

~~**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 identify each household member's potential for categorical and Title XXI eligibility as defined in R9-31-101.~~
~~**B.** Application for categorical eligibility. If a household that includes 1 or more of the following, who the county identified under subsection (A) as being potentially categorically eligible or Title XXI-eligible, the county shall forward the application to DES or the Administration for determination of categorical or Title XXI eligibility for the household member, unless the household member is already categorically eligible or Title XXI-eligible.~~
~~1. A pregnant woman;~~
~~2. A dependent child born on or after October 1, 1983;~~
~~3. A nonpregnant hospitalized applicant 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;~~
~~4. A person applying for SESP under R9-22-1613;~~
~~5. Any person who is determined eligible for MI/MN under this Article.~~
~~**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.~~
~~1. The county eligibility staff shall forward an application to DES or to the Administration under subsection (B) with all available documentation and verification 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.~~
~~2. 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 Title XXI eligibility or 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 requested before forwarding the application or that the county eligibility staff receives after forwarding the application.~~

~~3. Application forwarding requirements are waived if the applicant listed in subsection (B) has an application for medical assistance pending determination by DES or the Administration.~~

~~4. Waiver of application forwarding requirements under subsection (D)(3) does not waive the applicant's requirement to cooperate.~~

~~**E.** Conditions for approval. If the county eligibility staff forwards an application for an applicant listed in subsections (B)(1) through (B)(4) 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 pregnant or born on or after October 1, 1983, 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.~~

~~**G.** Other referrals. If an applicant is potentially categorically eligible or Title XXI-eligible under the screening requirements in subsection (A), and the county eligibility staff is not required to forward the application to DES or the Administration under subsection (B), the county eligibility staff shall refer the person to DES for categorical eligibility or to the Administration for Title XXI eligibility.~~

R9-22-1611. ~~Eligibility for Medicare Beneficiaries~~ Repealed

~~**A.** General.~~

~~1. Definition. In this Section, "geographically available" means a person is eligible to enroll in a Medicare HMO based on the person's place of residence.~~

~~2. Exceptions. This Section does not apply to a person who:~~

~~a. Has had a transplant as specified in A.R.S. § 36-2905; or~~

~~b. May not be enrolled in a Medicare HMO because:~~

~~i. The person resides in a location where no Medicare HMO is geographically available, or~~

~~ii. 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 determined 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. A 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. A person who meets the requirements for 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 a 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, Specified Low Income Medicare Beneficiary, and Qualifying Individuals 1 programs 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 before 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 geographically available Medicare HMOs operating 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 geographically available Medicare HMO, or~~
   b. ~~If coverage from a premium-free Medicare HMO becomes available.~~
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).~~

R9-22-1612. ~~State-Funded Coverage for Children~~ Repealed

~~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).~~

R9-22-1613. ~~State Emergency Service Program (SESP)~~ Repealed

~~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.~~

R9-22-1615. ~~Certification Periods~~ Repealed

~~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.~~

R9-22-1616. ~~Denial or Discontinuance of MI/MN Eligibility~~ Repealed

~~**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 limit specified in A.R.S. § 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, 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 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 sample review or quality control case analysis under 9 A.A.C. 22, Article 9.~~
~~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.~~

~~**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 or Title XXI eligibility process under A.R.S. § 36-2905(H);~~
~~13. The head-of-household requests a withdrawal of an application or a discontinuance of a household member's coverage; and~~
~~14. The person is an adult and requests a withdrawal of an application or a discontinuance of that person's own coverage.~~

R9-22-1617. ~~Notice of Action for Eligibility~~ Repealed

~~**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.~~

R9-22-1618. ~~Communication of Eligibility Determinations to the Administration~~ Repealed

~~**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.~~

R9-22-1619. ~~Rights Following Receipt of a Notice of Denial or Discontinuance of Coverage~~ Repealed

~~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.~~

R9-22-1620. ~~Retroactive Coverage for MI/MN, ELIC, and SESP~~ Repealed

~~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.~~

R9-22-1622. ~~Verification of Information for MI/MN Eligibility~~ Repealed

~~**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.~~

R9-22-1623. ~~Residence Requirements for MI/MN Eligibility~~ Repealed

~~**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. ~~ny 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.~~

R9-22-1624. ~~Citizenship and Alien Status Requirements for MI/MN Eligibility~~ Repealed

~~**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).~~

R9-22-1625. ~~Household Composition for MI/MN Eligibility~~ Repealed

~~**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.~~

R9-22-1626. ~~Annual Income for MI/MN Eligibility~~ Repealed

~~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.~~

R9-22-1627. ~~Resources for MI/MN Eligibility~~ Repealed

~~**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 judgment 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.~~

R9-22-1628. ~~Transfer of Resources for MI/MN Eligibility~~ Repealed

~~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.~~

R9-22-1629. ~~Assignment of Rights~~ Repealed

~~**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.~~

R9-22-1630. ~~MI/MN Interim Changes~~ Repealed

~~**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).~~

R9-22-1631. ~~MI/MN Redeterminations~~ Repealed

~~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.~~

R9-22-1633. ~~Case Record for MI/MN Applications~~ Repealed

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.~~

R9-22-1634. ~~Eligibility Office Locations and Hours of Operation~~ Repealed

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.~~

R9-22-1636. ~~Verification Review by the Director~~ Repealed

~~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.~~

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 FESP as defined in R9-22-101 or the SESP 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.~~

1. Except as provided in subsections (3), (4), and (C), a member, determined eligible under this Chapter and residing in an area served by more than one contractor, shall have freedom of choice in the selection of a contractor serving the member's GSA within 16 days from the date of the initial interview. A Native American member may select IHS or another available contractor.
2. If the member does not make a choice, the Administration shall auto-assign the member to IHS if the member is a Native American living on a reservation, a contractor based on family continuity, or the auto-assignment algorithm.
3. The Administration shall enroll a member with 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:
   a. The member no longer resides in the contractor's GSA,
   b. The contractor's contract is suspended or terminated,
   c. The member was previously enrolled with CMDP but at the time of re-enrollment the member is not a foster care child,
   d. The member chooses another contractor or chooses IHS, if available to the member, during the annual enrollment choice period, or
   e. The member was previously enrolled with a contractor but at the time of re-enrollment the member is a foster care child.
4. The Administration shall not enroll a member with a contractor if a member:
   a. Is eligible for the FESP;
   b. 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;
   c. Is eligible only for a retroactive period of eligibility, except for a member who is enrolled with IHS;
   d. Is not a Native American and resides in an area not served by a contractor; or
   e. Is a Native American and resides in an area not served by a contractor or IHS.

B. Fee-for-service coverage. A member not enrolled with a contractor under subsection ~~(A)(1)~~ (A)(4) shall obtain covered medical services from an AHCCCS-registered provider on a fee-for-service basis ~~as provided in~~ under 9 A.A.C. 22, Article 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), (A)(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 a 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 a Native American, shall not have 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.**~~**D.** Family Planning Services Extension Program. A member eligible ~~under~~ for the Family Planning Services Extension Program, as ~~defined in~~ under ~~R9-22-1435~~ R9-22-1424, shall remain enrolled with the member's contractor of ~~record.~~ record, or IHS.

~~**G.**~~**E.** ~~Enrollment changes~~ Contractor or IHS enrollment change for a member.

1. ~~A member may change contractors during the annual enrollment choice period.~~ The Administration shall change a member's enrollment if the member requests a change to an available contractor or IHS during an annual enrollment period. A Native American may change from an available contractor to IHS or from IHS to an available contractor at any time.
2. The Administration ~~may~~ shall approve ~~the~~ transfer a change for an enrolled member ~~from 1 contractor to another~~ as ~~specified in 9 A.A.C. 22, Article 5~~ under this Article, or as determined by the Director.
3. The Administration shall approve a change in ~~contractor~~ enrollment for any member if the change is a result of ~~a grievance, resolved through the grievance process specified in~~ the final outcome of a grievance under 9 A.A.C. 22, Article 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)~~ (A)(2).
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), (A)(2)(a), (A)(2)(b)(iv), (D), (E), (F), (G), and (H) apply if IHS is the contractor.~~

~~**J.** CMDP. The provisions of subsections (A)(1)(d), (A)(1)(e), and (H) apply if CMDP is the contractor.~~

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~~ A member's date of enrollment is 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~~ 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.

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.~~

1. The Administration shall enroll a newborn child of an AHCCCS eligible mother with a contractor or IHS, based on the mother's enrollment.
2. The Administration shall auto-assign a newborn child of an AHCCCS eligible mother who is not enrolled with a contractor or who is enrolled with CMDP.
3. The Administration shall notify the mother of the right to choose a different contractor for her child within 16 days from the date of the initial interview.

B. Financial liability for all newborns. The contractor shall be financially liable for the medical care of ~~the~~ a 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 or IHS, if available, for the newborn. ~~The mother of a noncategorical newborn shall not receive freedom of choice in the selection of a contractor.~~

R9-22-1704. ~~Categorical and EAC~~ Guaranteed Enrollment Period

~~**A.** General.~~

1. ~~The Administration shall grant a guaranteed enrollment period to a categorical or EAC member as provided in this Section 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 member.~~
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.~~

A. Except for members enrolled with IHS or CMDP, the Administration shall provide a guaranteed enrollment period for a one time period which begins on the effective date of the member's initial enrollment with the contractor and ends on the last day of the fifth full calendar month.

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. Was factually ineligible when initially enrolled with the contractor,
   ~~1.~~2. Except as provided in 9 A.A.C. 22, Article 12, is an inmate of a public institution as defined in 42 CFR 435.1009,
   ~~2.~~3. Dies,
   ~~3.~~4. Moves out-of-state,
   ~~4.~~5. Voluntarily withdraws from the AHCCCS program, or
   ~~5.~~6. Is ~~adopted,~~ adopted.
   ~~6. Is an EAC-eligible member and age 14, or~~
   ~~7. Is an EAC-eligible member 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~~ to which the member is not entitled effective on:
   1. The date the member is admitted to a public institution ~~specified in~~ under subsection (B);
   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 moved out-of-state;
   4. The date the Administration receives written notification of the member's voluntary withdrawal from the AHCCCS program; or
   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;~~ proceedings.
   ~~6. The last day of the month in which an EAC member 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~~ under subsection (C).

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ARIZONA LONG-TERM CARE SYSTEM

PREAMBLE

1. Sections Affected — **Rulemaking Action**

Sections Affected	Rulemaking Action
R9-28-101	Amend
R9-28-204	Amend
R9-28-401	Amend
R9-28-402	Amend
R9-28-406	Amend
R9-28-407	Amend
R9-28-408	Amend
R9-28-416	Amend
R9-28-1101	Amend
R9-28-1103	Amend
R9-28-1104	Amend
R9-28-1105	Amend
R9-28-1106	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 36-2932(M)

Implementing statute: Laws 2001, Chapter 344

3. The effective date of the rules:

October 1, 2001

4. A list of all previous notices appearing in the Register addressing the exempt rule:

Notice of Rulemaking Docket Opening: 7 A.A.R 2660, June 22, 2001

Notice of Public Meeting on Open Rulemaking Docket: 7 A.A.R. 2960, July 6, 2001

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS, Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from the regular rulemaking procedures:

AHCCCS is amending these rules to implement the new provisions of Proposition 204 and Laws 2001, Ch. 344 relating to behavioral health, eligibility, and covered services in A.R.S. §§ 36-2901, 36-2903.01, 36-2907, 36-2934, and 36-2939. Proposition 204 gives AHCCCS the authority to streamline and simplify eligibility. AHCCCS is exempt from the rulemaking requirements under Title 41, Chapter 6, of the Arizona Revised Statutes under Laws 2001, Ch. 344, § 113.

7. A reference to any study that the agency relied on in its evaluation of or justification for the rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

Not applicable

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:
Not applicable

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):
Not applicable

11. A summary of the principal comments and the agency response to them:
No comments were received.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
Not applicable

13. Incorporations by reference and their location in the rules:

Description	Date	Location
AFDC State Plan	July 16, 1996	R9-28-402

14. Was this rule previously adopted as an emergency rule? If so, please indicate the Register citation:
No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ARIZONA LONG-TERM CARE SYSTEM

ARTICLE 1. DEFINITIONS

Section
R9-28-101. General Definitions

ARTICLE 2. COVERED SERVICES

Section
R9-28-204. Institutional Services

ARTICLE 4. ELIGIBILITY AND ENROLLMENT

Section
R9-28-401. General
R9-28-402. Categorical Requirements and Coverage Groups
R9-28-406. ALTCS Living Arrangements
R9-28-407. Resource Criteria for Eligibility
R9-28-408. Income Criteria for Eligibility
R9-28-416. Enrollment with the FFS Program

ARTICLE 11. BEHAVIORAL HEALTH SERVICES

Section
R9-28-1101. General Requirements
R9-28-1103. Eligibility for Covered Services
R9-28-1104. General Service Requirements
R9-28-1105. Scope of Behavioral Health Services
R9-28-1106. General Provisions and Standards for Service Providers

ARTICLE 1. DEFINITIONS

R9-28-101. General Definitions

A. Location of definitions. Definitions applicable to Chapter 28 are found in the following:

Definition	Section or Citation
~~“211”~~	~~42 CFR 435.211~~
“210”	42 CFR 435.210
“217”	42 CFR 435.217
“236”	42 CFR 435.236

“Administration”	A.R.S. § 36-2931
“ADHS”	R9-28-111
“Aggregate”	R9-22-107
“AHCCCS”	R9-22-101
“Algorithm”	R9-28-104
“ALTCS”	A.R.S. § 36-2932
“ALTCS acute care services”	R9-28-104
“Alternative HCBS setting”	R9-28-101
“Ambulance”	R9-22-102
“Bed hold”	R9-28-102
“Behavior intervention”	R9-28-102
“Behavior management ~~services”~~ service”	R9-28-111
“Behavioral health evaluation”	R9-28-111
~~“Behavioral health paraprofessional”~~	~~R9-28-111~~
“Behavioral health medical practitioner”	R9-28-111
“Behavioral health professional”	R9-28-111
“Behavioral health service”	R9-28-111
“Behavioral health technician”	R9-28-111
“Billed charges”	R9-22-107
“Board-eligible for psychiatry”	R9-28-111
“Capped fee-for-service”	R9-22-101
“Case management plan”	R9-28-101
~~“Case management services”~~	~~R9-28-111~~
“Case manager”	R9-28-101
“Case record”	R9-22-101
“Categorically-eligible”	A.R.S. § 36-2934
“Certification”	R9-28-105
“Certified psychiatric nurse practitioner”	R9-28-111
“CFR”	R9-28-101
“Clean claim”	A.R.S. § 36-2904
“Clinical supervision”	R9-28-111
“CMS”	R9-22-101
“Community Spouse”	R9-28-104
“Contract”	R9-22-101
“Contractor”	~~R9-22-101~~ A.R.S. § 36-2901
“County of fiscal responsibility”	R9-28-107
“Covered services”	R9-22-102
“CPT”	R9-22-107
“CSRD”	R9-28-104
“Day”	R9-22-101
“DES Division of Developmental Disabilities”	~~A.R.S. § 36-1~~ A.R.S. § 36-551
“De novo hearing”	R9-28-111
“Developmental disability”	A.R.S. § 36-551
“Diagnostic services”	R9-22-102
“Director”	R9-22-101
“Disenrollment”	R9-22-117
“DME”	R9-22-102
“Eligible person”	A.R.S. § 36-2931
“Emergency medical services”	R9-22-102
“Encounter”	R9-22-107
“Enrollment”	R9-22-117
“Estate”	A.R.S. § 14-1201
~~“Evaluation”~~	~~R9-28-111~~
“Facility”	R9-22-101
“Factor”	R9-22-101
“Fair consideration”	R9-28-104
“FBR”	R9-22-101
“Grievance”	R9-22-108

“GSA” R9-22-101
“Guardian” R9-22-116
“HCBS” A.R.S. §§ 36-2931 and 36-2939
“Health care practitioner” R9-28-111
“Hearing” R9-22-108
“Home” R9-28-101
“Home health services” R9-22-102
“Hospital” R9-22-101
“ICF-MR” 42 CFR 435.1009 and 440.150
“IHS” R9-28-101
“IMD” 42 CFR 435.1009 and R9-28-111
“Indian” P.L. 94-437
~~“Inpatient psychiatric facilities for individuals under age 21” R9-28-111~~
“Institutionalized” R9-28-104
“Interested Party” R9-28-106
“JCAHO” R9-28-101
“License” or “licensure” R9-22-101
“Medical record” R9-22-101
“Medical services” R9-22-101
“Medical supplies” R9-22-102
“Medically eligible” R9-28-104
“Medically necessary” R9-22-101
“Member” A.R.S. § 36-2931
“Mental disorder” R9-28-111
“MMMNA” R9-28-104
“NF” 42 U.S.C. 1396r(a)
“Noncontracting provider” A.R.S. § 36-2931
“Occupational therapy” R9-22-102
“Partial care” R9-28-111
“PAS” R9-28-103
“PASARR” R9-28-103
“Pharmaceutical service” R9-22-102
“Physical therapy” R9-22-102
“Physician” R9-22-102
“Post-stabilization services” 42 CFR 438.114
“Practitioner” R9-22-102
“Primary care provider” R9-22-102
“Primary care provider services” R9-22-102
“Prior authorization” R9-22-102
“Prior period coverage” R9-28-101
~~“Prior-quarter period” R9-28-101~~
“Private duty nursing services” R9-22-102
“Program contractor” A.R.S. § 36-2931
“Provider” A.R.S. § 36-2931
“Prudent layperson standard” 42 U.S.C. 1396u-2
“Psychiatrist” R9-28-111
“Psychologist” R9-28-111
“Psychosocial rehabilitation” R9-28-111
“Quality management” R9-22-105
“RBHA” R9-28-111
“Radiology” R9-22-102
“Reassessment” R9-28-103
“Redetermination” R9-28-104
“Referral” R9-22-101
“Reinsurance” ~~R9-22-101~~ R9-22-107
“Representative” R9-28-104
“Respiratory therapy” R9-22-102
“Respite care” R9-28-102

"RFP"	R9-22-106
"Room and board"	R9-28-102
"Scope of services"	R9-22-102
~~"Screening"~~	~~R9-28-111~~
"Section 1115 Waiver"	A.R.S. § 36-2901
"Speech therapy"	R9-22-102
"Spouse"	R9-28-104
"SSA"	P.L. 103-296, Title I
"SSI"	R9-22-101
"Subcontract"	R9-22-101
~~"Substance abuse"~~	~~R9-28-111~~
~~"Treatment"~~	~~R9-28-111~~
"Utilization management"	R9-22-105
"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:

"AHCCCS" is defined in 9 A.A.C. 22, Article 1.

"ALTCS" means the Arizona Long-term Care System as authorized by A.R.S. § 36-2932.

"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:

For a person with a developmental disability (DD) specified in A.R.S. § 36-551:
Community residential setting defined in A.R.S. § 36-551;
Group home defined in A.R.S. § 36-551;
State-operated group home defined in A.R.S. § 36-591;
Family foster home ~~defined in~~ under 6 A.A.C. 5, Article 58;
Group foster home defined in 6 A.A.C. 5, Article 59;
Licensed residential facility for a person with traumatic brain injury specified in A.R.S. § 36-2939; ~~and~~
Adult Therapeutic Foster Home defined in 9 A.A.C 20, Articles 1 and 15; and
~~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;~~
Behavioral health service agency specified in A.R.S. § 36-2939(C) and 9 A.A.C. 20, Articles 1, 4, 5, and 6 for Levels I, II, or III; and 9 A.A.C. 20, Articles 1 and 14 for Rural Substance Abuse Transitional Agency.

For a person who is elderly or physically disabled (EPD), and the facility, setting, or institution is registered with AHCCCS:
Adult foster care homes defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939; an assisted living home or residential unit, as defined in A.R.S. § 36-401, and as authorized in A.R.S. § 36-2939.
Licensed residential facility for a person with a traumatic brain injury specified in A.R.S. § 36-2939;~~ and~~
Adult Therapeutic Foster Home defined in 9 A.A.C. 20, Articles 1 and 15; and
~~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~~
Behavioral health service agency specified in A.R.S. § 36-2939(C) and 9 A.A.C. 20, Articles 1, 4, 5, and 6 for Levels I, II, or III; and 9 A.A.C. 20, Articles 1 and 14 for Rural Substance Abuse Transitional Agency; and
Alzheimer's treatment assistive living facility demonstration pilot project as specified in Laws 1999, Ch. 313, § 35.

"Capped fee-for-service" is defined in 9 A.A.C. 22, Article 1.

"Case management plan" means a service plan developed by a case manager that involves the overall management of a member's care, and the continued monitoring and reassessment of the member's need for services.

"Case manager" means a person who is either a degreed social worker, a licensed registered nurse, or a person with a minimum of ~~2~~ two years of experience in providing case management services to a person who is elderly and physically disabled or has developmental disabilities.

"Case record" is defined in 9 A.A.C. 22, Article 1.

"CFR" means Code of Federal Regulations, unless otherwise specified in this Chapter.

"Contract" is defined in 9 A.A.C. 22, Article 1.

"Day" is defined in 9 A.A.C. 22, Article 1.

"DES Division of Developmental Disabilities" is defined in A.R.S. § 36-551.

"Director" is defined in 9 A.A.C. 22, Article 1.

"Disenrollment" is defined in 9 A.A.C. 22, Article 1.

"Eligible person" is defined in A.R.S. § 36-2931.

"Enrollment" is defined in 9 A.A.C. 22, Article 1.

"Facility" is defined in 9 A.A.C. 22, Article 1.

"Factor" is defined in 9 A.A.C. 22, Article 1.

"FBR" means Federal Benefit Rate and is defined in 9 A.A.C. 22, Article 1.

"GSA" is defined in 9 A.A.C. 22, Article 1.

"HCBS" means home and community based services defined in A.R.S. §§ 36-2931 and 36-2939.

"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:

Health care institution defined in A.R.S. § 36-401;
Residential care institution defined in A.R.S. § 36-401;
Community residential facility defined in A.R.S. § 36-551; or
Behavioral health service facility defined in ~~9 A.A.C. 20, Articles 6, 7, and 8.~~ 9 A.A.C. 20, Articles 1, 4, 5, and 6.

"Hospital" is defined in 9 A.A.C. 22, Article 1.

~~"GSA" is defined in 9 A.A.C. 22, Article 1.~~

"ICF-MR" means an intermediate care facility for the mentally retarded and is defined in 42 CFR 435.1009 and 440.150.

"IHS" means the Indian Health ~~Services.~~ Service.

"Indian" is defined in P.L. 94-437.

"JCAHO" means the Joint Commission on Accreditation of Healthcare Organizations.

"License" or "licensure" is defined in 9 A.A.C. 22, Article 1.

"Medical record" is defined in 9 A.A.C. 22, Article 1.

"Medical services" is defined in 9 A.A.C. 22, Article 1.

"Medically necessary" is defined in 9 A.A.C. 22, Article 1.

"Member" is defined in A.R.S. § 36-2931.

"NF" means nursing facility and is defined in 42 U.S.C. 1396r(a).

"Noncontracting provider" is defined in A.R.S. § 36-2931.

"Prior period coverage" means the period of time from the ~~1st~~ first day of the month of application or the ~~1st~~ first eligible month whichever is later to the day a member is enrolled with the program contractor. The program contractor receives notification from the Administration of the member's enrollment.

~~"Prior-quarter period" means the 3 calendar months immediately preceding the month of application during which a member may be eligible for services covered under this Chapter, retroactively under federal law and under A.R.S. § 36-2937.~~

"Program contractor" is defined in A.R.S. § 36-2931.

"Provider" is defined in A.R.S. § 36-2931.

"Referral" is defined in 9 A.A.C. 22, Article 1.

"Reinsurance" is defined in 9 A.A.C. 22, Article 1.

"SSA" means Social Security Administration defined in P.L. 103-296, Title I.

"SSI" is defined in 9 A.A.C. 22, Article 1.

"Subcontract" is defined in 9 A.A.C. 22, Article 1.

ARTICLE 2. COVERED SERVICES

R9-28-204. Institutional Services

A. Institutional services shall be provided in:
1. A nursing facility ~~as defined in~~ under R9-28-101;
2. An "ICF-MR" ~~as defined in~~ under R9-28-101; or
3. An "IMD" ~~as defined in~~ under 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~~ under 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~~ Under 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~~ under 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.~~ Subpart I.
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 for members age 21 and over 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 for members age 21 and older is limited to ~~9~~ nine days per AHCCCS contract year. A physician order is required for leave from the facility for ~~1~~ one 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;
   c. A combination of therapeutic leave and bedhold days, totaling no more than 21 days per contract year, may be taken by members under 21 years of age.
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~~ under R9-28-510.

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).~~ (G).
6. If an applicant dies while an application is pending, the Administration shall complete an eligibility determination for the deceased applicant.
7. The Administration shall complete an eligibility determination on an application filed on behalf of a deceased applicant, provided the application is filed in the month of the person's death or earlier.

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~~ one of the ALTCS coverage groups listed in R9-28-402(B) are met. The conditions of eligibility are:
1. Categorical requirements ~~specified in~~ under R9-28-402;
2. Citizenship and alien status ~~specified in~~ under R9-28-404;
3. SSN ~~specified in~~ under R9-28-405;
4. Living arrangements ~~specified in~~ under R9-28-406;
5. Resources ~~specified in~~ under R9-28-407;
6. Income ~~specified in~~ under R9-28-408;
7. Transfers ~~specified in~~ under 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~~ first-and third parties and shall cooperate by:
   a. Establishing paternity and obtaining medical support and payments, except for ~~poverty-level~~ pregnant women ~~specified in~~ under A.A.C. ~~R9-22-1422(C)~~ R9-22-1421, unless the person establishes good cause under 42 CFR 433.147 for not cooperating; and
   b. Identifying and providing information to assist the Administration in pursuing ~~1st-and 3rd-parties~~ first-and third-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~~ under R9-28-403; ~~and~~
11. Medical eligibility specified in ~~Article 3.~~ Article 3; and
12. Providing information and verification specified in Section D.

C. Persons eligible for Title ~~IV-E, Title XVI, or 42 U.S.C. 1396u-1.~~ IV-E or Title XVI. To be determined eligible for ALTCS, a person eligible for Title IV-E ~~(Foster Care/Adoption Subsidy),~~ or 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~~ under R9-28-402,
2. SSN ~~specified in~~ under R9-28-405,
3. Living arrangements ~~specified in~~ under R9-28-406,
4. Resources ~~specified in~~ under R9-28-407,
5. Transfers of assets ~~specified in~~ under R9-28-409,
6. Income ~~specified in~~ under R9-28-408,
7. Citizenship and alien status ~~specified in~~ under R9-28-404,
8. ~~1st-and 3rd-party~~ First-and third-party liability ~~specified in~~ under subsection (B)(8),
9. Application for potential benefits ~~specified in~~ under subsection (B)(9),
10. State residency ~~specified in~~ under R9-28-403,
11. Medical conditions ~~specified in~~ under 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~~ first day of the month that all eligibility requirements are met but no earlier than ~~the prior quarter period specified in subsection (G).~~ the month of application.

~~**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.**~~**G.** 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~~ which is the amount the person shall pay toward the cost of ~~care).~~ 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.**~~**H.** 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~~ under A.A.C. R9-22-512.

I. Title VI Compliance. The Administration shall determine eligibility under the provisions of this Article. The Administration 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 U.S.C., Section 2000d, and rules and regulations promulgated according to, or as otherwise provided by law.

R9-28-402. Categorical Requirements and Coverage Groups

A. Categorical requirements. As a condition of ALTCS eligibility, a person shall meet ~~1~~ one 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.~~ Subpart F.

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.~~ 20 CFR 404.716.
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.~~ 42 U.S.C. 1382c(a)(2).
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~~ under Article 3.
4. Child. A child is a person defined in A.A.C. ~~R9-22-1401(B).~~ R9-22-1420.
5. Pregnant.
   a. Pregnancy shall be medically verified by ~~1~~ one 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.~~ under Section 2 of the AFDC State Plan as it existed on July 16, 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. ALTCS coverage groups. In addition to other requirements in this Article, a person shall meet ALTCS eligibility criteria in ~~1~~ one of the following coverage groups:

1. A coverage group ~~described in A.R.S. § 36-2901(4)(b)~~ under A.R.S. §§ 36-2901(6)(a)(i) or 36-2901(6)(a)(ii).
2. The ~~211~~ 210 coverage group specified in ~~42 CFR 435.211.~~ 42 CFR 435.210. A person in the ~~211~~ 210 coverage group is medically eligible as specified in Article 3 and would be eligible for SSI cash assistance or ~~the 1931 group specified in A.A.C. R9-22-1406 if the person is not in a medical institution~~. meets the criteria for AFDC under Section 2 of the AFDC State Plan as it existed on July 16, 1996.
3. The 236 coverage group ~~specified in~~ under 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~~ under 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).

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~~ one of the following settings:

1. Institutional settings:
   a. A ~~nursing facility (NF)~~ NF defined in 42 U.S.C. 1396r(a),
   b. An ~~institution for mental disease (IMD)~~ IMD for a person who is either under age 21 or age 65 or older~~,~~ or a person aged 21 through 64 for up to 30 days per admission and no more than 60 days per contract year under the Administration's Section 1115 Waiver with CMS,
   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 gross income limit is ~~300%~~ 300 percent of the FBR for a person meeting the requirements of the 236 coverage group ~~specified in~~ under R9-28-402(B) and who resides in ~~1~~ one 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 net income limit is ~~100%~~ 100 percent 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~~ one of the following settings:
   a. At home or in an alternative HCBS setting if a person refuses HCBS service; or
   b. A room in an assisted living center, or a licensed assisted living home or center which is not registered with ~~AHCCCS;~~ 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.

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; or
3. A person receiving a Title IV-E Adoption ~~Assistance; or~~ Assistance.
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),~~ (D), if a person's ~~Medicaid~~ ALTCS 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, 1994incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.~~ 42 U.S.C. 1382(a)(3), 42 U.S.C. 1382b, and 20 CFR 416 Subpart L.

C. ~~Except as provided in subsections (D)(1) and (2), if~~ If a person's ~~Medicaid~~ ALTCS 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.~~ determined as a member of a family group including a dependent child, the Administration shall use the resource criteria in Section 2 of the AFDC State Plan as it existed on July 16, 1996 to determine eligibility.

D. The Administration permits exceptions to the resource criteria for a person identified in ~~subsections (B) and (C)~~ subsection (B):
1. Resources of a responsible relative (spouse or parent) are disregarded beginning the ~~1st~~ first 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;

h. The value of a payment refunded by a nursing facility after ALTCS approval for six months beginning with the month of receipt. The Administration shall evaluate the refund in accordance with R9-28-409 if transferred without receiving something of equal value.

~~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. 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).

F. Trusts are evaluated in accordance with federal and state laws to determine eligibility.

~~E.~~G. A person is not eligible for long-term care services if countable resources exceed the following ~~limitations~~ limits:

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 Secretary of State. This incorporation by reference contains no future editions or amendments~~; 20 CFR 416.1205.
2. For a person described 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.~~ under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII), there is no resource limit ~~specified in A.A.C. R9-22-1406(I) and (J)~~.

~~F.~~H. A person shall provide information and verification necessary to determine the countable value of resources.

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; or
3. A person receiving a Title IV-E Adoption ~~Assistance; or~~ Assistance.

~~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~~ If a person's ~~Medicaid~~ ALTCS 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~~ count the income described in 42 U.S.C. 1382a and 20 CFR 416 Subpart K to determine eligibility with the following exceptions:

1. Income types excluded by 42 U.S.C. 1382a(b) for determining net income are also excluded in determining gross income to determine eligibility;
2. Income of a responsible relative (parent or spouse) is counted as part of income under 42 CFR 435.602, except that the income of a responsible relative is disregarded the month the person is institutionalized;
3. In-kind support and maintenance, under 42 U.S.C. 1382a(a)(2)(A), are excluded for both net and gross income tests;
4. The income exceptions under A.A.C. R9-22-1503(A)(2) apply to the net income test; and
5. Income described in subsection (E).

C. ~~Except as provided in subsection (D), if~~ If a person's ~~Medicaid~~ ALTCS eligibility is ~~most closely related to 42 U.S.C. 1396u-1~~ determined as a member of a family with a dependent child ~~and the person is not included in subsection (A)~~, the Administration shall use the methodology in ~~A.A.C. R9-22-1428 through R9-22-1430 and 42 U.S.C. 1396a(a)(17)(D) is used~~ Section 2 of the AFDC State Plan as it existed on July 16, 1996 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. For a person whose eligibility is determined under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), or 42 U.S.C. 1396a(a)(10)(A)(i)(VII), the methodology in A.A.C. R9-22-1403 is used to determine eligibility in accordance with 42 CFR 435.602.

~~D.~~E. The following are income exceptions.

~~1. The following are income exceptions for a person identified in subsections (B) and (C):~~

~~a.~~1. 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.~~2. 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.~~ 42 U.S.C. 1396r-5(b).

~~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.**~~**F.** 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%~~ 300 percent of the FBR;
2. For a person or a couple in the SSI-related 210 coverage group specified in R9-28-402(B), ~~100%~~ 100 percent 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)~~ under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII) and is:
   a. ~~A child born after September 30, 1983, who is at~~ A child who is at least age ~~6~~six but less than age 19; ~~100%~~ 100 percent of the FPL, adjusted by household size;
   b. A child age ~~1~~ one through ~~5~~ five, ~~133%~~ 133 percent of the FPL, adjusted by household size; or
   c. A child less than age ~~1~~ one or a pregnant woman, ~~140%~~ 140 percent 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,~~ who is a member of a family with a dependent child, the standards specified in ~~A.A.C. R9-22-1406(H)~~ Section 2 of the AFDC State Plan as it existed on July 16, 1996 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.**~~**G.** 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~~ under 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~~ (d);
   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~~ under 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%~~ 15 percent of the FBR for a person residing in a medical institution for a full calendar month. A personal-needs allowance equal to ~~300%~~ 300 percent 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 in ~~A.A.C. R9-22-1406(B)~~ Section 2 of the AFDC State Plan as it existed on July 16, 1996 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)~~ (6) if these expenses have not been paid or are not subject to payment by a ~~3rd~~ third-party, but the person still has the obligation to pay the expense, and ~~1~~ one 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~~ six 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~~ third-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.**~~**H**.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.~~ 20 CFR 416.203.

R9-28-416. Enrollment with the FFS Program

A. No tribal or EPD program contractor in GSA. The Administration shall enroll an ALTCS elderly or physically disabled member who resides in an area with no ALTCS tribal program contractor or EPD program contractor in the AHCCCS FFS program ~~as specified in~~ under A.R.S. § 36-2945.

~~**B.** Prior-quarter period. The Administration shall enroll a member in ALTCS FFS program if a member is eligible during the prior-quarter period for that period as specified in A.R.S. § 36-2937.~~

~~**C.**~~**B.**Prior period coverage. The Administration shall enroll a member in AHCCCS fee-for-service program if a member is eligible for ALTCS services only during prior period coverage.

ARTICLE 11. BEHAVIORAL HEALTH SERVICES

R9-28-1101. General Requirements

General requirements. The following general requirements apply to behavioral health services provided under this Article, subject to all exclusions and limitations.

1. Administration. The program shall be administered ~~as specified in~~ under A.R.S. § 36-2932.
2. Provision of services. Behavioral health services shall be provided ~~as specified in~~ under A.R.S. § 36-2939 and this Chapter.
3. Definitions. The following definitions apply to this Article:
   - ~~a. "Emergency or crisis behavioral health services" specified in 9 A.A.C. 20.~~
   - ~~b.~~a. "Physician assistant" ~~specified in~~ under A.R.S. § 32-2501. In addition, a physician assistant providing a behavioral health service shall be supervised by an AHCCCS-registered psychiatrist.
   - b. "Respite" as defined under A.A.C. R9-22-1201.
   - c. "Substance abuse" as defined under A.A.C. R9-22-1201.
   - d. "Therapeutic foster care services" as defined under A.A.C. R9-22-1201.

R9-28-1103. Eligibility for Covered Services

A. Eligibility for covered services. A member determined eligible under A.R.S. § 36-2934 shall receive medically necessary covered services specified in R9-28-1105.

B. Ineligibility. A person is not eligible for behavioral health services if the person is:

1. An inmate of a public institution as defined in 42 CFR 435.1009,
2. A resident of an institution for the treatment of tuberculosis, or
3. Age 21 through 64, ~~and~~ who is a resident of an ~~IMD.~~ IMD, and who exceeds the limits under Article 11.

R9-28-1104. General Service Requirements

A. Services. Behavioral health services include both mental health and substance abuse services.

B. Medical necessity. A service shall be medically necessary as specified in R9-28-201.

C. Prior authorization. A service shall be provided by contractors, subcontractors, and providers consistent with prior authorization requirements established by the Director and ~~specified in~~ under R9-28-1105.

D. EPSDT. For Title XIX members, EPSDT services shall include all medically necessary Title XIX-covered behavioral health services for a member.

E. Experimental services. The Director shall determine whether a service is experimental, or whether a service is provided primarily for the purpose of research. Those services shall not be covered.

F. Gratuities. A service or an item, if furnished gratuitously to a member by a provider, is not covered and payment shall be denied.

G. Service area. Behavioral health services rendered to a member shall be provided within the contractor's service area except when:

1. A contractor's primary care provider refers a member to another area for medical specialty care;
2. A member's medically necessary covered service is not available within the service area;
3. A net savings in behavioral health service delivery costs can be documented by the RBHA for a member. Undue travel time or hardship shall be considered for a member or a member's family; or
4. A member is placed in an NF or Alternative HCBS setting located out of the contractor's service area.

H. Travel. If a member travels or temporarily resides out of a behavioral health service area, covered services are restricted to emergency behavioral health care, unless ~~otherwise~~ authorized by the member's contractor.

I. Noncovered services. If a member requests a behavioral health service that is not covered by the Administration or is not authorized by a contractor, the behavioral health service may be provided by an AHCCCS-registered behavioral health service provider under the following conditions:

1. The requested service and the itemized cost of each service is documented by a contractor and provided to the member or the member's guardian; and
2. The member or member's guardian signs a statement acknowledging:
   - a. Services have been explained to the member or member's guardian, and
   - b. The member or member's guardian accepts responsibility for payment.

J. Referral. If a member is referred out of a contractor's service area to receive a prior authorized, medically necessary, behavioral health service or a medically necessary covered service, the service shall be provided by the contractor.

K. Restrictions and limitations. ~~The restrictions, limitations, and exclusions in this Article shall not apply to a contractor when electing to provide a noncovered service.~~

1. The restrictions, limitations, and exclusions in this Article shall not apply to a contractor when electing to provide a noncovered service.
2. Room and board is not a covered service unless provided in an Level I, inpatient, sub-acute, or residential center under R9-28-1105.

L. Residential placement. Behavioral health services are covered in an Alternative HCBS setting or home as specified in R9-28-101(B). ~~Room and board is not a covered service as defined in R9-28-102 unless provided in an inpatient facility specified in R9-28-1105(B).~~

M. Appropriate settings. A behavioral health service shall be provided in an allowable Alternative HCBS setting that meets state and federal licensing standards and that is allowable under A.R.S. § 36-2939.

R9-28-1105. Scope of Behavioral Health Services

A. Inpatient behavioral health services. The following inpatient services shall be covered subject to the limitations and exclusions in this Article.

1. Inpatient behavioral health services provided in a Medicare (Title XVIII) certified hospital include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment. The behavioral health service shall be provided under the direction of a physician in:
   a. A general acute care ~~hospital;~~ hospital, or
   b. An inpatient psychiatric ~~facility for a person under 21 years of age, licensed as a psychiatric hospital or a residential treatment center licensed as a Level I Psychiatric Facility and accredited by an AHCCCS-approved accrediting body as specified in contract and authorized by federal laws and regulations; or~~ hospital.
   ~~c. An IMD for a member age 21 through 64, licensed as a psychiatric hospital or an NF.~~
2. Inpatient service limitations:
   a. Inpatient services, other than emergency services specified in this Section, shall be prior authorized.
   b. Inpatient services shall be reimbursed on a per diem basis and shall be inclusive of all services and room and board, except the following may bill independently for services:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant, ~~as defined in this Article, or~~
      iv. A ~~psychologist.~~ psychologist,
      v. A certified independent social worker,
      vi. A certified marriage and family therapist,
      vii. A certified professional counselor, or
      viii. A behavioral health medical practitioner.
   ~~c. The following services may be billed independently if prescribed by a provider specified in subsection (B)(1)(b) for a member residing in a residential treatment center:~~
      ~~i. Laboratory;~~
      ~~ii. Radiology; and~~
      ~~iii. Psychotropic medication, medication monitoring, and medication adjustment.~~
   ~~d.~~c. A member age 21 through 64 ~~as defined in 42 CFR 441.150~~ is ~~not~~ eligible for behavioral health services provided in an IMD except as specified in 42 CFR 441.151 and under this Section up to 30 days per admission and no more than 60 days per contract year as allowed under the Administration's Section 1115 Waiver with CMS. These limitations do not apply to a member under age 21 and age 65 or over.

B. ~~Partial care. The following partial care services shall be covered subject to the limitations and exclusions in this Article.~~

~~1. Partial care shall be provided as either a basic or intensive level of care to:~~
   ~~a. Meet a member's need for behavioral health treatment, and~~
   ~~b. Prevent placing a member in a higher level of care or a more restrictive environment.~~
      ~~i. Basic partial care services shall be provided as specified in 9 A.A.C. 20.~~
      ~~ii. Intensive partial care services shall be provided as specified in 9 A.A.C. 20.~~
~~2. Partial care service limitations. All services shall be included in the partial care reimbursement rate, practitioners may bill independently:~~
   ~~a. A psychiatrist,~~
   ~~b. A certified psychiatric nurse practitioner,~~
   ~~c. A physician assistant as defined in this Article, and~~
   ~~d. A psychologist.~~

Level I Residential Treatment Center Services. The following Residential Treatment Center services shall be covered subject to the limitations and exclusions in this Article.

1. Level I Residential Treatment Center services shall be provided under the direction of a physician in a Level I Residential Treatment Center accredited by an AHCCCS approved accrediting body as specified in contract.
2. Residential Treatment Center services include room and board and treatment services for mental health and substance abuse conditions.
3. Residential Treatment Center service limitations:
   a. Services shall be prior authorized, except for emergency services as specified in this Section.

b. Services shall be reimbursed on a per diem basis and shall be inclusive of all services, except the following may bill independently for services:
i. A psychiatrist,
ii. A certified psychiatric nurse practitioner,
iii. A physician assistant,
iv. A psychologist,
v. A certified independent social worker,
vi. A certified marriage and family therapist,
vii. A certified professional counselor, or
viii. A behavioral health medical practitioner.
4. The following services may be billed independently if prescribed by a provider specified in this Section:
a. Laboratory,
b. Radiology, and
c. Psychotropic medication.

C. ~~Outpatient services. The following outpatient services shall be covered subject to the limitations and exclusions in this Article.~~
~~1. Outpatient services shall include the following:~~
~~a. Screening provided by a behavioral health professional or a behavioral health technician;~~
~~b. Evaluation provided by a behavioral health professional;~~
~~c. Counseling including individual therapy, group, and family therapy provided by a behavioral health professional or a behavioral health technician under the clinical supervision of a behavioral health professional;~~
~~d. Behavior management provided by a behavioral health professional, a behavioral health technician, or a behavioral health paraprofessional; and~~
~~e. Psychosocial rehabilitation provided by a behavioral health professional, a behavioral health technician, or a behavioral health paraprofessional.~~
~~2. Outpatient service limitations:~~
~~a. The following practitioners may bill independently:~~
~~i. A psychiatrist,~~
~~ii. A certified psychiatric nurse practitioner,~~
~~iii. A physician assistant as defined in this Article, and~~
~~iv. A psychologist.~~
~~b. Other behavioral health professionals, behavioral health technicians, and behavioral health paraprofessionals not specified in subsection (D)(2)(a) shall be employed by, or contracted with, an AHCCCS-registered behavioral health agency.~~

Level I Sub-acute Facility Services. The following sub-acute facility services shall be covered subject to the limitations and exclusions in this Article.
1. Level I sub-acute facility services shall be provided under the direction of a physician in a Level I sub-acute facility accredited by an AHCCCS approved accrediting body as specified in contract.
2. Level I sub-acute services include room and board and treatment services for mental health and substance abuse conditions.
3. Services shall be reimbursed on a per diem basis and shall be inclusive of all services, except the following may bill independently for services:
a. A psychiatrist,
b. A certified psychiatric nurse practitioner,
c. A physician assistant,
d. A psychologist,
e. A certified independent social worker,
f. A certified marriage and family therapist,
g. A certified professional counselor, or
h. A behavioral health medical practitioner.
4. The following services may be billed independently if prescribed by a provider specified in this Section:
a. Laboratory,
b. Radiology, and
c. Psychotropic medication.
5. A member age 21 through 64 eligible for behavioral health services provided in an IMD except as specified in 42 CFR 441.151 as defined in this Section up to 30 days per admission and no more than 60 days per contract year as allowed under the Administration's Section 1115 Waiver with CMS. These limitations do not apply to a member under age 21 and age 65 or over.

D. ~~Behavioral health emergency services. The following emergency services are covered subject to the limitations and exclusions in this Article.~~
   ~~1. An RBHA shall ensure that behavioral health emergency services are provided by the qualified personnel specified in R9-22-1206. The emergency services shall be available 24 hours-per-day, 7 days-per-week in the RBHA's service area in emergency situations when a member is a danger to self or others or is otherwise determined in need of immediate unscheduled behavioral health services. Behavioral health emergency services may be provided on either an inpatient or outpatient basis.~~
   ~~2. A health plan shall provide behavioral health emergency services on an inpatient basis not to exceed 3 days per emergency episode and 12 days per contract year, for a member not yet enrolled with an RBHA.~~
   ~~3. An inpatient emergency service provider shall verify the eligibility and enrollment of a member through the Administration to determine the need for notification to a health plan or an RBHA and to determine the party responsible for payment of services under Article 7.~~
   ~~4. Behavioral health emergency service limitations:~~
      ~~a. An emergency behavioral health service does not require prior authorization. The provider shall, however, comply with the notification requirements specified in R9-22-210.~~
      ~~b. A behavioral health service for an unrelated condition, that requires evaluation, diagnosis, and treatment shall be prior authorized by an RBHA.~~

ADHS licensed Level II Behavioral Health Residential Services. The following Level II Behavioral Health Residential services shall be covered subject to the limitations and exclusions in this Article.
1. Level II Behavioral Health services shall be provided by a licensed Level II agency.
2. Services shall be inclusive of all covered services except room and board.
3. The following may bill independently for services:
   a. A psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A physician assistant,
   d. A psychologist,
   e. A certified independent social worker,
   f. A certified marriage and family therapist,
   g. A certified professional counselor, or
   h. A behavioral health medical practitioner.

E. ~~Other behavioral health services. Other behavioral health services include:~~
   ~~1. Case management as defined in R9-22-112;~~
   ~~2. Laboratory and radiology services for behavioral health diagnosis and medication management;~~
   ~~3. Psychotropic medication and related medication included in a health plan's or an RBHA's formulary; and~~
   ~~4. Medication monitoring, administration, and adjustment for psychotropic medication and related medications.~~

ADHS licensed Level III Behavioral Health Residential Services. The following Level III Behavioral Health Residential services shall be covered subject to the limitations and exclusions in this Article.
1. Level III Behavioral Health services shall be provided by a licensed Level III agency.
2. Services shall be inclusive of all covered services except room and board.
3. The following may bill independently for services:
   a. A psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A physician assistant,
   d. A psychologist,
   e. A certified independent social worker,
   f. A certified marriage and family therapist,
   g. A certified professional counselor, or
   h. A behavioral health medical practitioner.

F. ~~Transportation services.~~
   ~~1. Emergency transportation shall be covered for a behavioral health emergency specified in R9-22-211. Emergency transportation is limited to behavioral health emergencies.~~

Partial care. The following partial care services shall be covered subject to the limitations and exclusions in this Article.
1. Partial care shall be provided by an agency qualified to provide a regularly scheduled day program of individual member, group or family activities that are designed to improve the ability of the member to function in the community.
2. Partial care service exclusions. School attendance and educational hours shall not be included as a partial care service and shall not be billed concurrently with these services.

G. Outpatient services. The following outpatient services shall be covered subject to the limitations and exclusions in this Article.

1. Outpatient services shall include the following:
   a. Screening provided by a behavioral health professional or a behavioral health technician;
   b. Initial behavioral health evaluation provided by a behavioral health professional;
   c. Ongoing behavioral health evaluation by a behavioral health professional or a behavioral health technician;
   d. Counseling including individual therapy, group, and family therapy provided by a behavioral health professional or a behavioral health technician;
   e. Behavior management services provided by qualified individuals or agencies as specified in contract; and
   f. Psychosocial rehabilitation services provided by qualified individuals or agencies as specified in contract.
2. Outpatient service limitations:
   a. The following practitioners may bill independently:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant as defined in this Article,
      iv. A psychologist,
      v. A certified independent social worker,
      vi. A certified professional counselor,
      vii. A certified marriage and family therapist,
      viii. A behavioral health medical practitioner,
      ix. A therapeutic foster parent, and
      x. Other AHCCCS registered providers as specified in contract.
   b. Other behavioral health professionals and qualified persons not specified in subsection (G)(2)(a) shall be employed by, or contracted with, an AHCCCS-registered behavioral health agency.

H. Behavioral health emergency services. The following emergency services are covered subject to the limitations and exclusions in this Article.
1. A RBHA shall ensure that behavioral health emergency services are provided by the qualified personnel under A.A.C. R9-22-1206. The emergency services shall be available 24 hours-per-day, seven days-per-week in the RBHA's service area in emergency situations when a member is a danger to self or others or is otherwise determined in need of immediate unscheduled behavioral health services. Behavioral health emergency services may be provided on either an inpatient or outpatient basis.
2. A contractor shall provide behavioral health emergency services under A.A.C. R9-22-210(D) on an inpatient basis not to exceed three days per emergency episode and 12 days per contract year, for a member not yet enrolled with a RBHA.
3. An inpatient emergency service provider shall verify the eligibility and enrollment of a member through the Administration to determine the need for notification to a contractor or a RBHA and to determine the party responsible for payment of services under Article 7.
4. Behavioral health emergency service limitations:
   a. An emergency behavioral health service does not require prior authorization. The provider shall, however, comply with the notification requirements under A.A.C. R9-22-210.
   b. A behavioral health service for an unrelated condition, that requires evaluation, diagnosis, and treatment shall be prior authorized by a RBHA.

I. Other behavioral health services. Other behavioral health services include:
1. Case management under A.A.C. R9-22-1201;
2. Laboratory and radiology services for behavioral health diagnosis and medication management;
3. Psychotropic medication and related medication;
4. Medication monitoring, administration, and adjustment for psychotropic medication and related medications;
5. Respite care;
6. Therapeutic foster care services provided in a family foster home under 6 A.A.C. 5, Article 58 or adult therapeutic foster home under 9 A.A.C. 20 Articles 1 and 15;
7. Personal assistance; and
8. Other support services to maintain or increase the member's self-sufficiency and ability to live outside an institution.

J. Transportation services.
1. Emergency transportation shall be covered for a behavioral health emergency under A.A.C. R9-22-211. Emergency transportation is limited to behavioral health emergencies.
2. Non-emergency transportation shall be covered to and from covered behavioral health service providers.

R9-28-1106. General Provisions and Standards for Service Providers

A. Qualified service provider. A qualified behavioral health service provider shall:
1. Be a non-contracting provider or employed by, or contracted in writing with, a contractor or a subcontractor to provide behavioral health services to a member;

2. Have all applicable state licenses or certifications, or comply with alternative requirements established by the Administration;
3. Register with the Administration as a behavioral health service provider; and
4. Comply with all requirements ~~specified in~~ under Article 5 and this Article.

B. Quality and utilization management.

1. Service providers shall cooperate with the contractor's quality and utilization management, ADHS, and the Administration as ~~specified in~~ under R9-28-511 and contract.
2. Service providers shall comply with applicable procedures ~~specified in 42 CFR 456, August 23, 1996, 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.~~ under 42 CFR 456.

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 30. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PREMIUM SHARING PROGRAM

PREAMBLE

1. Sections Affected | **Rulemaking Action**

Sections Affected	Rulemaking Action
R9-30-101	Amend
R9-30-102	Amend
R9-30-103	Amend
R9-30-107	Amend
R9-30-201	Amend
R9-30-204	Amend
R9-30-205	Amend
R9-30-206	Amend
R9-30-208	Amend
R9-30-209	Amend
R9-30-210	Amend
R9-30-211	Amend
R9-30-212	Amend
R9-30-213	Amend
R9-30-215	Amend
R9-30-216	Amend
R9-30-217	Amend
R9-30-301	Amend
R9-30-302	Amend
R9-30-303	Amend
R9-30-304	Amend
R9-30-305	Amend
R9-30-306	Amend
R9-30-401	Amend
R9-30-403	Amend
R9-30-404	Amend
R9-30-407	Amend
R9-30-409	Amend
R9-30-501	New Section
R9-30-502	Amend
R9-30-504	Amend
R9-30-507	Amend
R9-30-509	Amend
R9-30-510	Amend
R9-30-512	Amend
R9-30-513	Amend

R9-30-518	Amend
R9-30-524	Amend
R9-30-601	Amend
R9-30-603	Amend
R9-30-701	Amend
R9-30-702	Amend
R9-30-703	Amend
R9-30-801	Amend
R9-30-802	Amend
R9-30-803	Amend
R9-30-804	Amend
R9-30-805	Amend
R9-30-806	Amend
R9-30-807	Amend
R9-30-808	Amend
R9-30-809	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 36-2923 and 36-2923.01

Implementing statutes: A.R.S. §§ 36-2923, 36-2923.01 and 36-2923.02

3. The effective date of the rules:

October 1, 2001

4. A list of all previous notices appearing in the Register addressing the exempt rule:

Notice of Rulemaking Docket Opening: 7 A.A.R. 2658, June 22, 2001

Notice of Public Meeting on Open Rulemaking Docket: 7 A.A.R. 2968, July 6, 2001

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCSA, Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

Fax (602) 256-6756

6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from the regular rulemaking procedures:

Laws 2001, Ch. 385 § 16 exempts the Administration from the rulemaking requirements of A.R.S. Title 41, Chapter 6 for the purposes of implementing the Premium Sharing Program (PSP) statewide. The Administration amended all articles in 9 A.A.C. 30 to comply with recent statutory changes made by Laws 2001, Ch. 385 and to provide additional clarification to the rule language.

7. A reference to any study that the agency relied on in its evaluation of or justification for the rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

Not applicable

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

Not applicable

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

R9-30-701(G)(4)(b), in the proposed rule, indicated a $10 co-pay for branded drugs. The co-pay was changed in the final rule to $20. This same subsection had no clarifying language for those circumstances where there is no suitable generic for the branded drug. The following clarifying language was added: "the generic copayment applies to

branded prescription medications for which there is no FDA rated A-B generic equivalent." More explanation is included in item 11.

11. A summary of the principal comments and the agency response to them:

A summary of the principal comments is as follows:

TOPIC	COMMENT	ACTION	RATIONALE
EMERGENCY ROOM (ER) CO-PAY	Have $25 co-pay Have tiered co-pay	Have $50 co-pay	Reflects commercial single co-payment Adequate to encourage individuals to only seek ER care as appropriate
PRESCRIPTION DRUGS CO-PAY	Use generic drug co-pay for branded drug when no reasonably generic equivalent exists Decreasing the branded drug co-pay from 50 percent of the drug cost to a $10 co-pay may be a disincentive to purchasing the generic drug	Agreed and language clarified Modification	The change clarifies the language and facilitates claims adjudication questions Co-pay changed to $20. The financial impact of the higher co-pay provides an incentive for the member to choose the lower cost generic drug when it is available. The $20 co-pay is, in many cases, still less than 50% of the branded drug cost.
INSURANCE	Waive or eliminate 30 day waiting period when a person voluntarily drops health insurance: a. excessive premiums b. Limited benefits c. Other	Comply with statute	Per A.R.S. § 36-2923.03 only permits PSP administration to adopt rules on involuntary reasons

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

13. Incorporations by reference and their location in the rules:

None

14. Was this rule previously adopted as an emergency rule? If so, please indicate the Register citation:

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 30. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PREMIUM SHARING ~~DEMONSTRATION PROJECT~~ PROGRAM

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
R9-30-107. Payment Responsibilities Related Definitions

ARTICLE 2. SCOPE OF SERVICES

Section
R9-30-201. General Requirements
R9-30-204. Inpatient General Hospital Services
R9-30-205. Primary Care Provider Services
R9-30-206. Organ and Tissue Transplantation 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)
R9-30-215. 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
R9-30-403. 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 Protest; ~~Appeal~~ Request for Hearing

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Section
R9-30-501. ~~Reserved~~ General Authority
R9-30-502. Availability and Accessibility of Services
R9-30-507. Member Record
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
R9-30-518. Information to an Enrolled Member
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 REQUEST FOR HEARING

Section
R9-30-601. General Provisions for a Grievance and a Request for Hearing
R9-30-602. Grievance
R9-30-603. Eligibility Hearing for an Applicant and a ~~Premium Share~~ Member
Exhibit A. Grievance and Request for Hearing Process

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 FOR EXPEDITED HEARINGS

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 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

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
"Abuse"	R9-30-101
"AHCCCS"	R9-22-101
"Ambulance"	R9-22-102
"Applicant"	R9-30-101
"Chronic disease"	R9-30-102
"Chronically ill" member"	R9-30-102
"Clean claim"	A.R.S. § 36-2904
"Contract year"	R9-30-101
"Contractor"	R9-22-101
"Copayment"	R9-30-107
"Covered services"	R9-30-102
"Date of application"	R9-30-103
"Date of notice"	R9-22-108
"Day"	R9-22-101
"Eligible for AHCCCS benefits"	R9-30-103
"Eligible household member"	R9-30-101
"Emergency medical services"	R9-22-102
"Enrollment"	R9-30-103
"E.P.S.D.T. services"	R9-22-102
"FPL"	R9-30-103
"Fund"	A.R.S. § 36-2923
"Grievance"	R9-22-108
"Head-of-household"	R9-30-103
"Hearing"	R9-22-108
"Hospital"	R9-22-101
"Household income"	R9-30-103
"Household unit"	R9-30-103
"Inpatient hospital services"	R9-30-101
"Life threatening"	R9-27-102
"Medical record"	R9-22-101
"Medical services"	R9-22-101
"Medically necessary"	R9-22-101
"Member"	R9-30-103
"Month of application"	R9-30-103
"Noncontracting provider"	A.R.S. § 36-2931
"Offeror"	R9-22-106
"Other health care practitioner"	R9-27-101
"Outpatient hospital services"	R9-22-107
"Pharmaceutical services"	R9-22-102
~~"Plan"~~	~~Laws 1997, Ch.186, § 3, as amended by Laws 1997, 2nd Special Session, Ch.1, § 1; Laws 1998, Ch. 214, § 21~~
~~"Population"~~	~~Laws 1997, Ch. 186,§ 3, as amended byLaws 1997, 2nd Special Session, Ch.1, § 1; Laws 1998,Ch. 214, § 21~~

~~“Practitioner”~~ ~~R9-22-102~~
“Premium” R9-30-107
“Premium Share” R9-30-107
~~“Premium Share member”~~ ~~R9-30-103~~
“Pre-payment” R9-30-107
“Prescription” R9-22-102
“Primary care provider” R9-22-102
“Prior authorization” R9-22-102
“Providers” A.R.S. § 36-2901
“PSA” R9-30-101
~~“PSDP”~~ “PSP” R9-30-101
“Quality management” R9-22-105
“Redetermination” R9-30-103
“Referral” R9-22-101
“Respondent” R9-22-108
“RFP” R9-22-105
“Service area” R9-30-103
“Scope of services” R9-22-101
“Subcontract” R9-22-101
“System” A.R.S. § 36-2901
“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.

“Abuse” means the inappropriate 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 physiologic dependence or impairment.

“Applicant” means a person who submits, or on whose behalf is submitted, a signed and dated application for enrollment in the ~~PSDP~~ PSP.

“Contract year” means October 1 through September 30.

“Eligible household member” means a person in a household unit that is eligible for ~~PSDP~~ PSP coverage under this Chapter.

“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~~ primary care provider or other health care practitioner upon referral from a ~~Premium Share~~ member’s primary care provider.

“PSA” means the Premium Sharing Administration, which is the entity designated by the AHCCCS Director to

carry out the administrative functions of the ~~PSDP~~ PSP ~~under Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21~~ A.R.S. § 36-2923.01.

~~“PSDP”~~ “PSP” means Premium Sharing ~~Demonstration Project~~ Program~~, which is a 3-year pilot program established~~ under A.R.S. § ~~36-2923~~ 36-2923.01.

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~~ abuse, and if not treated has a reasonable medical probability of causing a life-threatening situation or death. For the purposes of the ~~PSDP~~ PSP, 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~~ as defined under Laws 2001, Ch. 385, § 14:

~~a.~~ Alpha-1-Antitrypsin Deficiency,
~~b.~~ ~~Amytrophic~~ Amyotrophic 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~~ Acquired immunodeficiency syndrome, Human immunodeficiency virus,
~~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~~ PSP, who has been diagnosed with a chronic disease as defined in ~~subsection (1)~~ this Section and who has an annual gross household income at or below ~~400%~~ 400 percent 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~~ under A.R.S. § 36-2923.01.

~~3.~~ "Covered services" means the health and medical services specified in Article 2 of this Chapter.

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~~ PSP 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~~ PSP 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~~ PSP 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~~ one or more persons who reside together in a household and are considered in determining eligibility.

"Member" means an enrollee as defined under A.R.S. § 36-2923.01.

~~8.~~ "Month of application" means the calendar month during which a signed and dated ~~PSDP~~ PSP 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~~ PSP redetermination form by a current ~~Premium Share~~ member requesting continuation of ~~PSDP~~ PSP 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.

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 a 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%~~ six percent of the ~~Premium Share~~ member's gross annual household income, a ~~Premium Share~~ member whose household income is equal to or less than ~~200%~~ 250 percent of FPL must pay monthly under A.R.S. § 36-2923.01 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.

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; and Laws 1999, Ch. 313, § 31~~ under Laws 2001, Ch. 385, § 13.
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~~ PSP 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~~ public institution;
   b. A person who is in ~~residence at~~ an institution for the treatment of tuberculosis; or

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 do not require prior authorization; however, the ~~Premium Share~~ member shall notify the contractor as required in R9-30-210.
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~~ contractor 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~~ contractor's service area 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~~ contractor 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 noncovered 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; and Laws 1999, Ch. 313, § 31~~ under A.R.S. § 36-2923.01.

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~~ inpatient 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~~ under Laws 2001, Ch. 385, § 13.
   b. For the purpose of this Section, the ~~PSDP~~ PSP 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.

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~~ one 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 third-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~~ PSP 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. Except for breast reconstruction performed by a contracted ~~health plan~~ contractor following a mastectomy under R9-30-215, services or items provided to reconstruct or improve personal appearance after an illness or injury.

R9-30-206. Organ and Tissue Transplantation Services

A. A ~~Premium Share~~ member is eligible for the following organ transplantation services under A.R.S. § 36-2923.01 if prior authorized and coordinated with the ~~Premium Share~~ member's contractor:
1. Kidney transplantation~~;~~.
2. Cornea transplantation~~;~~, and
3. Immunosuppressant medications and other related services including medically necessary dental services required prior to and associated with a kidney or cornea transplant~~;~~.

B. In addition to a transplantation service in ~~subsections (A)(1) and (2)~~ subsection (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; and Laws 1999, Ch. 313, § 31~~ under Laws 2001, Ch. 385, § 14 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. Heart transplantation;
2. Liver transplantation;
3. Autologous and allogenic bone marrow transplantation;
4. Lung transplantation;
5. Heart-lung transplantation;
6. Other organ transplantation if the transplantation is required by A.R.S. § 36-2907, and if other statutory criteria are met; and
7. Immunosuppressant medications, chemotherapy, and other related services including medically necessary dental services required prior to and associated with a transplant.

C. Artificial or mechanical hearts and xenografts are not covered services for organ and tissue transplantation services.

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.

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~~ one 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.

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~~ seven 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~~ following 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.

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)~~ under Laws 2001, Ch. 385, § 13.

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 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 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~~ PSP 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.

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.

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;
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; and Laws 1999, Ch. 313, § 31~~ under Laws 2001, Ch. 385, § 13; and
14. Medically necessary breast ~~Breast~~ reconstruction performed by a contracted ~~health plan~~ contractor following a mastectomy under ~~Laws 1999, Ch. 313, § 31~~ A.R.S. § 36-2923.01.

B. The following shall be excluded as ~~PSDP~~ PSP 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.

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;~~
      i. Bandages,
      ii. Tape,
      iii. Ointments,
      iv. Peroxide,
      v. Alcohol, and
      vi. 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.

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~~ under Laws 2001, Ch. 385, § 13.

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~~ PSP 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.

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-30-301. General Requirements

A. Expenditure limit. Enrollment in the ~~PSDP~~ PSP 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 1999, Ch. 313, § 31, and Laws 1997, Ch. 186, § 4, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 2~~ under A.R.S. § 36-2923.01. The PSA will accept members subject to the availability of funds. The PSA shall place all eligible household members on a waiting list when the PSA projects that the program's appropriation will be expended for ~~Premium Sharing~~ members. For this subsection, "~~Premium Sharing~~ members" includes persons who have requested a hearing regarding a discontinuance.

B. Participation. Subject to the expenditure limitation specified in subsection (A) and the cap and waiting list requirements in subsections (D) and (E), 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~~ Each eligible household member shall complete and return a health history questionnaire ~~which shall be completed by each eligible household member and returned~~ with the 1st premium payment ~~for each eligible household member to be enrolled in the PSDP~~.

D. Chronically ill cap.
1. The total number of chronically ill members in the ~~PSDP~~ PSP shall not exceed 200 persons ~~as specified in Laws 1997, Ch. 186, § 4, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 2~~ under A.R.S. § 36-2923.01. When the ~~PSDP~~ PSP has reached the cap of 200 persons, and subject to the expenditure limit as specified in subsection (A), a household with an eligible chronically ill person shall be placed on a waiting list.
2. The chronically ill cap applies to each chronically ill ~~person~~ applicant whose gross income is less than or equal to ~~400%~~ 400 percent FPL.

E. Waiting list requirements.
1. General requirements.
   a. The PSA shall maintain separate lists for households with an eligible chronically ill person and households with no eligible chronically ill persons.
   b. Until the 200 person cap in subsection (D) has been reached, a household with an eligible chronically ill person takes priority over a household with no eligible chronically ill persons.
   c. Subject to subsections (E)(2) and (3), the PSA shall place all eligible household members on a waiting list in order of the household's eligibility determination date. The eligibility determination date shall be the date that PSA determines that all conditions of eligibility have been met. The PSA shall process mail received at PSA in the order it is received, by calendar date.
   d. The PSA shall enroll an eligible person in a household when sufficient spaces are available to enroll all eligible household members. ~~No later than 45 days from the date of notice from PSA that space is available to cover the number of eligible persons in a household, the household shall submit 2 months' premiums and a complete health history questionnaire under subsection (C). The PSA shall enroll all eligible household members under R9-30-304.~~
   e. No later than the 45th day following the date of notice from PSA that space is available, the household shall submit two months' of premiums and a complete health history questionnaire under subsection (C). The PSA shall enroll all eligible household members under R9-30-304.
2. Waiting list for ~~households~~ a household with an eligible chronically ill person.
   ~~a.~~ ~~If a member of an enrolled household with no eligible chronically ill persons is determined chronically ill, that person takes priority over a new application for a household with an eligible chronically ill person.~~
   ~~b.~~ If a member of an enrolled household with no eligible chronically ill persons is determined chronically ill, the ~~person~~ member shall: ~~shall remain in the general population until a chronically ill space is available.~~
   a. Take priority over a new application applicant for a household with an eligible chronically ill person, and
   b. Remain in the general population until a chronically ill space is available.

3. Waiting list for households with no eligible chronically ill persons. If a chronically ill member of a household with income equal to or below ~~200%~~ 250 percent FPL is determined no longer chronically ill, that person takes priority over a new application for a household with no eligible chronically ill persons.
4. Termination from a waiting list. An eligible person in a household on the waiting list shall be terminated from the waiting list for any of the following reasons:
   a. The person no longer meets the eligibility requirements of this Article;
   b. Verification of the death of a person;
   ~~c.~~ ~~Verification that a person no longer resides in a county in which the PSDP operates~~;
   ~~d.~~c. Voluntary withdrawal of the application for the ~~PSDP~~ PSP;
   ~~e.~~d. The person cannot be located and mail sent to the person is returned as undeliverable;
   ~~f.~~ e. The household fails to pay the 1st ~~2~~ two months' of premiums and complete the health history questionnaire; or
   ~~g.~~f. Verification of other insurance coverage~~; or~~.
   ~~h.~~ ~~The PSDP expires.~~

R9-30-302. Time-frames for Determining Eligibility

A. 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~~ An applicant shall provide the PSA with information and corresponding verification requested in subsection (A) within 15 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 in the order that all information necessary to determine eligibility is received by PSA, by calendar date, and within 30 days of receipt of that information.

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~~ one 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, and Laws 1999, Ch. 313, § 31~~ A.R.S. § 36-2923.01; 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 under A.R.S. § 36-2923.01. ~~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 1999, Ch. 313, § 31; 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 annualized gross household income from documentation submitted by the applicant that identifies income received by all household members during the full calendar month immediately prior to the month of application.
   b. The PSA shall count the annualized gross income from employment, self-employment, rental, public assistance benefits, and other earned and unearned income.
   c. ~~The following amounts shall be deducted~~ The PSA shall deduct the following amounts 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~~ PSP 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 income shall be disregarded~~ The PSA shall disregard the following income:
      i. Food stamps,
      ii. Earned income tax credits, and
      iii. Any portion of lump-sum income intended to cover a period of time prior to the 1-month income period in R9-30-303.
   e. PSA shall average income if income is received irregularly or regularly but from sources or in amounts which vary as follows:

i. Add together income from a representative number of weeks or months, and
ii. Divide the resulting sum by the same number of weeks or months to determine the average monthly amount.

f. PSA 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.
g. PSA shall evaluate income under a fixed-term employment contract as follows:
i. 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;
ii. If contract income is received before or during the time the work is performed, but not as specified in subsection (A)(3)(g)(i), prorate the income over the number of months in the contract; or
iii. If payment is received only upon completion of the work, the PSA shall divide the amount of the contract-payment by the number of months in the contract.
h. PSA shall use the actual amount of income received in a month if the ~~person~~ applicant:
i. Receives or expects to receive less than a full month's income from a new source,
ii. Loses a source of income, or
iii. Is paid daily.

4. Income limits. The annualized gross household income, less deductions shall not exceed ~~200%~~ 250 percent 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; and Laws 1999, Ch. 313, § 31~~ for a nonchronically ill member and ~~400%~~ 400 percent FPL for a chronically ill person under A.R.S. § 36-2923.01(L).
5. Income verification.
a. The applicant shall provide verification for all sources of income received by all household members ~~from all sources~~ during the full calendar month immediately prior to the month of application.
b. If the applicant fails to provide verification of income, the PSA shall deny the application.
6. Household composition. The PSA determines eligibility by household unit. All members of the household shall be included on the application. In computing the household size and income limit, a pregnant woman is counted as a minimum of two persons. 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;~~ A spouse as defined in A.A.C. R9-22-101. This includes a spouse who is temporarily away from home for employment or to seek 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.~~c. 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.~~d. ~~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.~~ A dependent child means a child who is unmarried, has not reached age 19, and
i. Is a biological child, adopted child, a step-child of the head-of-household or spouse or both, or
ii. The biological child of another dependent child who is a household member, or
iii. 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~~ under A.R.S. § 36-2923.01 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.

a. An applicant who has health care coverage or who voluntarily terminated health care coverage in the ~~6 months~~ 30 days prior to application for the ~~PSDP~~ PSP, including but not limited to any of the following applicants, is not eligible for coverage under the ~~PSDP~~ PSP under A.R.S. § 36-2923.01:
   i. An applicant who voluntarily terminated federal or state-funded health care coverage, ~~in the 6 months prior to application for the PSDP~~ except voluntary PSP terminations, which must wait 12 months under R9-30-305;
   ii. An applicant who had COBRA ~~in the 6 months prior to application for the PSDP~~ and who terminated COBRA before exhausting COBRA coverage;
   iii. An applicant who had COBRA ~~in the 6 months prior to application for the PSDP~~ and who terminated COBRA due to nonpayment of a premium;
   iv. An applicant who voluntarily terminated employment or was terminated due to gross misconduct or for cause;
   v. An applicant who failed to cooperate with the requirements of federal or state-funded health care coverage; and
   vi. An applicant who terminated health care coverage for non-payment of premiums or copayments.

b. Exclusions from the ~~6-month~~ 30 days bare requirement. An applicant who involuntarily terminated health care coverage in the ~~6 months~~ 30 days prior to application for the ~~PSDP~~ PSP, including but not limited to any of the following applicants, is excluded from the ~~6-month~~ 30 days bare requirement in subsection (A)(9)(a):
   i. An applicant whose employer terminated the applicant's employment other than for cause or gross misconduct;
   ii. An applicant whose employer altered the applicant's employment status, such as changing the applicant's hours from full-time to part-time;
   iii. An applicant who involuntarily terminated health care coverage due to divorce from an insured spouse;
   iv. An applicant who involuntarily terminated health care coverage due to death of an insured spouse;
   v. An applicant who became ineligible for coverage under the applicant's parent's insurance due to age or student status;
   vi. An applicant who involuntarily terminated health care coverage due to a loss of a job and who did not have the option to participate in COBRA;
   vii. An applicant who involuntarily terminated health care coverage due to a loss of a job and who had the option to participate in COBRA but who chose not to participate or pay the initial payment;
   viii. An applicant who involuntarily terminated health care coverage due to a loss of a job and who chose to participate in COBRA and exhausted COBRA coverage; and
   ix. An applicant who became ineligible for health care coverage by reaching a lifetime cap on expenditures imposed by the applicant's insurer.

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~~ PSP. A person who has full VA coverage shall not be eligible for PSP.
   b. Medicare benefits. An applicant who has Medicare Part A, Medicare Part B, or both, is not eligible for coverage under the ~~PSDP~~ PSP.
   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~~ PSP. 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 ~~Kids-Care~~ KidsCare prior to approval for the ~~PSDP~~ PSP.
   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; and Laws 1999, Ch. 313, § 31~~ PSP under A.R.S. § 36-2923.01.
   e. Payor of last resort. The AHCCCS Administration is the payor of last resort under A.R.S. § 36-2923.01. The PSA contractor shall not be the primary payor for any claim involving worker's compensation, automobile insurance, or homeowner's insurance.

B. ~~Requirements~~ Additional requirements for a chronically ill member or applicant.

1. Limited enrollment. There is a 200-space limit for the chronically ill. ~~An~~ The PSA shall place an applicant or member ~~shall be placed~~ on a waiting list once the spaces are filled or expenditure limits are reached ~~as specified in R9-30-301 and Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21; Laws 1999, Ch. 313, § 31; and Laws 1997, Ch. 186, § 4, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 2~~ under A.R.S. § 36-2923.01.

2. Other health care coverage. The requirements in subsection (A)(9) do not apply to a chronically ill member or applicant who has an annual gross household income greater than ~~200%~~ 250 percent but equal to or less than ~~400%~~ 400 percent 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 greater than 200% of FPL and equal to or less than 400% of FPL shall have been eligible for health care services under A.R.S. § 11-297 for at least 12 months out of the prior 15 consecutive months immediately preceding the month of application for the PSDP.~~
   ~~b.~~a. Medical verification. A member or applicant 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.~~b. Premium. A chronically ill member or applicant and each household member whose gross household income is equal to or less than ~~400%~~ 400 percent FPL but greater than ~~200%~~ 250 percent 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; and Laws 1999, Ch. 313, § 31~~ under A.R.S. § 36-2923.01.
   ~~d.~~c. Failure to claim chronic disease. A chronically ill member who fails to state that the member has ~~1~~ one 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; Laws 1999, Ch. 313, § 31;~~ under Laws 2001, Ch. 385, § 14 and R9-30-102 at the time of application may be denied, referred to the PSA for potential fraud, or both.

R9-30-304. Enrollment

A household shall pay the premiums for eligible household members ~~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 1999, Ch. 313, § 31,~~ under A.R.S. § 36-2923.01 for continued enrollment in the ~~PSDP~~ PSP.

1. ~~Health plan~~ Contractor choice.
   a. Each eligible household shall select a ~~health plan~~ contractor at the time of application.
   b. PSA shall enroll all eligible household members with the same ~~health plan~~ contractor.
   c. Each eligible household shall have freedom of choice of a ~~PSDP~~ PSP ~~health plan~~ contractor when there are ~~1~~ one or more ~~health plans~~ contractors in the service area.
2. Open enrollment. The eligible household may change contractors during the annual enrollment choice period.
3. Effective date of enrollment. The PSA shall enroll all eligible household members with the contractor under R9-30-701. ~~Premium Share members~~ Members shall be ineligible for retroactive coverage.

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; and Laws 1999, Ch. 313, § 31~~.

~~1.~~**A.**~~Reasons for disenrollment. A Premium Share~~ A member shall be disenrolled from the ~~PSDP~~ PSP under A.R.S. § 36-2923.01 for the following reasons:
   ~~a.~~1. Nonpayment of premiums for the household;
   ~~b. Moving out of the participating counties served by the PSDP~~;
   2. Untimely payments;
   ~~c.~~3. Providing false or fraudulent information on the Premium Sharing application;
   4. Violence, or threatening or other substantially abusive behavior toward the PSA or the PSP employees or agents, or contracting or noncontracting providers or their employees or agents;
   ~~d.~~5. The person no longer meets the eligibility requirements identified in R9-30-303 and ~~Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1; Laws 1998, Ch. 214, § 21; and Laws 1999, Ch. 313, § 31~~ A.R.S. § 36-2923.01; or
   ~~e. The PSDP expires; or~~
   ~~f.~~6. Failure or refusal to cooperate in the eligibility process or provide requested information.

~~2.~~**B.**~~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.~~**C.**Grievance and request for hearing process. A ~~Premium Share~~ member has a right to file a grievance or request for hearing as specified in Article 6.

~~4.~~**D.**~~PSDP~~ PSP participation. A ~~Premium Share~~ member who voluntarily terminates ~~PSDP~~ PSP eligibility shall not re-enroll for a period of 12 consecutive months under A.R.S. § 36-2923.01. 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; and Laws 1999, Ch. 313, § 31~~.

~~a.~~1. Disenrollment from the ~~PSDP~~ PSP or nonpayment of a premium is a voluntary termination and subject to the 12-month period.
~~b.~~2. Voluntary termination from ~~PSDP~~ PSP does not include a disenrollment from the ~~PSDP~~ PSP because of a change in employment status which causes the member's gross household income to exceed the income limit.

~~5.~~**E.** 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~~ PSP 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, and Laws 1999, Ch. 313, § 31~~ under A.R.S. § 36-2923.01(P).

R9-30-306. Redetermination

A. Except as provided in subsection (C), the PSA shall conduct a redetermination of eligibility on each Premium Sharing household unit every 12 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; and Laws 1999, Ch. 313, § 31,~~ under A.R.S. 36-2923.01 unless the household unit becomes ineligible prior to this time.

B. The 12-month period shall begin with the 1st day of the month following the eligibility determination date as determined under R9-30-301 or the most recent redetermination date.

C. The PSA shall conduct a redetermination on a ~~Premium Share~~ household unit when the PSA has reason to believe that a member's situation has changed and the change may affect eligibility or the premium amount paid by the member or household.~~:~~

~~1. A Premium Share member moves from 1 PSDP county to another participating PSDP PSP county or The PSA has reason to believe that a Premium Share member's situation has changed and the change may affect eligibility or the premium amount paid by the member or household.~~

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.R.S. § 36-2923.01. A contractor that has contracts and subcontracts entered into ~~in accordance with~~ under 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).

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~~ The Administration is authorized to contract with ~~AHCCCS' Health Plans~~ contractors under A.R.S. § ~~36-2912~~ 36-2923.01.

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~~ PSP under A.R.S. § 36-2923.01(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~~.

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 five years from the date of final payment or, for records relating to costs and expenses to which the PSA has taken exception, five 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 informa-

tion 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.

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 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 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.

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.

R9-30-409. Contract or Protest; ~~Appeal~~ Request for Hearing
The contractor shall file a grievance as specified in A.A.C. R9-22-804.

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-30-501. ~~Reserved~~ General Authority
The Director shall administer and implement the PSP and has full operational authority to carry out administrative functions under A.R.S. § 36-2923.01.

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, seven 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~~ one 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~~ one physician, registered nurse, physician's assistant, or nurse practitioner, accessible by telephone 24 hours a day, seven 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~~ 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.

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~~ under A.R.S. § 36-2923.01.

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~~ request for hearings;
3. Any informal complaints; and
4. Service information.

R9-30-509. Transition and Coordination of Member Care
The PSA shall coordinate and implement disenrollment and re-enrollment procedures when a ~~Premium Share~~ member's change of residence requires a change in contractor as specified in contract.

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.

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; and
~~6. State Data Exchange (SDX) tapes from the U.S. Social Security Administration; and~~
~~7.~~6. Information ~~system tapes~~ from the Arizona Department of Economic Security or AHCCCSA, 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~~ A person authorized by the person concerned~~;~~, and
3. ~~Persons or agencies~~ A person or agency 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~~ PSP-related confidential and safeguarded information regarding ~~Premium Share~~ a member or applicant, shall be released to ~~persons~~ a person 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~~ request for hearing 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~~ PSP 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~~ PSP; and
d. Performing evaluations and analyses of ~~PSDP~~ PSP operations;

2. For official purposes related to the administration of the ~~PSDP program~~ PSP 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~~ PSP.
   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~~ PSP.
   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.

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.

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.

C. 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.

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.

ARTICLE 6. GRIEVANCE AND REQUEST FOR HEARING

R9-30-601. General Provisions for a Grievance and a Request for Hearing

A. A grievance and a request for hearing under this Chapter shall comply with R9-22-801. All references in that rule to AHCCCS shall apply to PSA, and all references to ~~health plans~~ contractors and system providers shall apply to Premium Sharing Plans. The grievance and request for hearing process is illustrated in Exhibit A.

B. When requesting a hearing regarding an adverse action under this Chapter, PSA is the respondent.

R9-30-603. Eligibility Hearing for an Applicant and a ~~Premium Share~~ Member

A. Except as provided in this Section, an eligibility hearing for an applicant or a ~~Premium Share~~ member shall comply with R9-22-803.

B. Adverse eligibility action. An applicant and a ~~Premium Share~~ member may request a hearing concerning any of the following adverse eligibility actions:
1. Denial of eligibility. A denial of eligibility is an adverse decision that determines an applicant ineligible for ~~PSDP~~ PSP;
2. Discontinuance of eligibility. A discontinuance of eligibility is a termination of a ~~Premium Share~~ member's eligibility;
3. Determination of premium amount; or
4. Determination of chronic illness.

C. ~~PSDP~~ PSP coverage during the hearing process. A ~~Premium Share~~ member who requests a hearing regarding a discontinuance shall receive continued Premium Sharing coverage until a final administrative decision is rendered only if the ~~Premium Share~~ member pays for three full months worth of premiums under R9-30-701, which shall be received no later than 15 days after the date of notice.

D. Non-refundable premium. The Administration shall not refund any portion of the advance premiums paid.
1. If a ~~Premium Share~~ member's discontinuance is upheld, any remaining advance premium paid shall be applied toward the cost to the system.
2. If a ~~Premium Share~~ member's discontinuance is overturned, any remaining advance premium paid shall be applied to the next month's premium charge.

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; and Laws 1999, Ch. 313, § 31~~ under A.R.S. § 36-2923.01.

B. Monthly premium payment based on annual household income equal to or less than ~~200%~~ 250 percent FPL, determined by the ~~1~~ one-month income period. A ~~Premium Share~~ member whose gross household income is equal to or less than ~~200%~~ 250 percent FPL shall pay a share of the premium. The ~~Premium Share~~ member shall pay the share of the premium depending on the number of eligible household members and the gross household income.
1. For ~~1~~ one eligible household member, the premium share will be equal to ~~2.5%~~ three percent of the gross household income;
2. For ~~2~~ two eligible household members, the premium share will be equal to ~~3%~~ four percent of the gross household income;

3. For ~~3~~ three eligible household members, the premium share will be equal to ~~3.5%~~ five percent of the gross household income;
4. For ~~4~~ four or more household members, the premium share will be equal to ~~4%~~ six percent of the gross household income.

C. Premium payment for chronically ill person with gross household income greater than ~~200%~~ 250 percent and equal to or less than ~~400%~~ 400 percent of FPL. The PSA will require the chronically ill members and their eligible household members whose gross household income is greater than ~~200%~~ 250 percent and equal to or less than ~~400%~~ 400 percent 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 shall pay the premium for the 1st ~~2~~ two 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 are nonrefundable.
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,
   c. Money order, or
   d. Other means approved by the PSA.
3. A ~~Premium Share~~ member whose payment is returned for nonsufficient funds shall pay the monthly premium in the form of a:
   a. Cashier's check,
   b. Money order, or
   c. Other means approved by the PSA.

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; and Laws 1999, Ch. 313, § 31~~ under A.R.S. § 36-2923.01(B) and (G)

1. $10 for each physician visit,
2. $~~25~~ $50 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%~~ percent ~~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;~~
4. Prescriptions:
   a. $5 for generic,
   b. $20 for formulary brand name prescriptions; the generic copayment applies to branded prescription medications for which there is no FDA rated A-B generic equivalent.

~~6.~~5. $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.~~6. $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.~~7. $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.~~8. $10 for individual outpatient behavioral health services. ~~Premium Share~~ members are eligible for a maximum of 30 outpatient behavioral health visits annually;
~~10.~~9. $5 for outpatient behavioral health group services; and
~~11.~~10. 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; and Laws 1999, Ch. 313, § 31~~ under A.R.S. § 36-2923.01.

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. 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; and Laws 1999, Ch. 313, § 31~~ under A.R.S. § 36-2923.01(L). The PSA may adjust the ~~initial~~ capitation rates~~,~~. ~~except that any increase exceeding 10%~~ percent ~~of the established rate shall 1st be reviewed by the oversight committee as specified in Laws 1997, Ch. 186, § 5~~ The oversight committee reviews changes to capitation rates, premiums and copayments under A.R.S. § 36-2923.02.

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~~ PSP 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 providers, 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, 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 first receiving verification from the PSA that the person was ineligible for ~~PSDP~~ PSP on the date of service or that the services provided were not covered by ~~PSDP~~ PSP

K. ~~Premium Share member~~ Member withheld information. The prohibition in subsection (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 third-party to the ~~Premium Share~~ member when the payment duplicates the ~~PSDP~~ PSP benefits and the payment has not been assigned to the contractor.

L. First- and third-party collections and coordination of benefits. The PSA shall recover all First- and third-party collections and coordinate benefits under 9 A.A.C. 22, Article 10 and ~~Laws 1997, Ch. 186, § 3, as amended by Laws 1997, 2nd Special Session, Ch. 1, § 1; Laws 1998, Ch. 214, § 21; and Laws 1999, Ch. 313, § 31~~ A.R.S. § 36-2923.01. The PSA is entitled to all rights for liens and claims under A.R.S. §§ 36-2915 and 36-2916.

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~~ <u>For the remaining counties in Arizona</u>.
      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~~%~~ <u>percent</u> of billed charges.

D. Transfer of payments. The PSA or a contractor shall meet the requirements in A.A.C. R9-22-704.

ARTICLE 8. MEMBERS' RIGHTS AND RESPONSIBILITIES FOR EXPEDITED HEARINGS

R9-30-801. General Intent and Definitions

A. This Article defines the notice and expedited hearing process when a ~~Premium Share~~ contractor denies, reduces, suspends, or terminates a service that requires prior authorization. This Article provides an expedited hearing process and opportunity for continued services as an alternative to the provisions of 9 A.A.C. 30, Article 6. The expedited hearing process is illustrated in 9 A.A.C. 30, Article 6, Exhibit A.

B. Definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Article have the following meanings unless the context explicitly requires another meaning:

"Action" means a denial, termination, suspension, or reduction of a service.

"Contractor" means a health plan, Arizona Department of Health Services Division of Behavioral Health Services, or a Tribal or Regional Behavioral Health Authority.

"Notice" means a written statement that meets the requirements specified in R9-30-804.

"Party" means a member or contractor.

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 three business days after the date the Administration or a contractor denies authorization for a requested service that the ~~Premium Share~~ member does not currently receive.

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 at least 10 days before the effective date of the intended action.

R9-30-804. Content of Notice

A notice required under R9-30-802 or R9-30-803 shall contain the following:

1. A statement of the action the ~~Premium Share~~ contractor has taken or intends to take;
2. The specific reason for the action, including the specific facts, personal to the member, that support the action;
3. The specific law, rule, or other written policy, standards, or criteria that supports the action, or the specific change in federal or state law that authorizes the action;
4. 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
5. An explanation of the circumstance under which the ~~Premium Share~~ contractor shall continue a covered service if a ~~Premium Share~~ member requests a hearing regarding a service that is:
   a. Reduced,
   b. Suspended, or
   c. Terminated.

R9-30-805. Exceptions from an Advance Notice

A ~~Premium Share~~ contractor may mail a notice for a reduction, suspension, or termination of a service no 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 that requires a reduction or a termination of a service and indicates that the ~~Premium Share~~ member understands that a reduction or termination of a service shall be the result of that information;
3. Learns that a ~~Premium Share~~ member has been admitted to an institution that makes the ~~Premium Share~~ member ineligible for 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.

R9-30-806. Notice in a Case of Probable Fraud

A ~~Premium Share~~ contractor may shorten the advance notice period to five 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.

R9-30-807. Expedited Hearing Process

A. Request for expedited hearing.

1. If a ~~Premium Share~~ contractor denies, reduces, suspends, or terminates a service that requires authorization, a member is entitled to an expedited hearing if a member files a request for hearing under the time frames in subsection (B).
2. A member shall file a request for expedited hearing or a request for expedited hearing and continued services in the same manner as provided in R9-22-803.

B. Time frames. A member shall file a request for hearing with the Administration or the contractor:
1. No later than 10 business days after the date of personal delivery of the notice to the ~~Premium Share~~ member; or
2. No later than 15 business days after the postmark date, if mailed, of the notice.

C. Expedited hearing. A hearing under this Section shall be held no sooner than 20 days, and not later than 40 days, after the PSA's receipt of the request for hearing. The hearing may be held sooner than 20 days after the Administration's receipt of the request for hearing upon the agreement of all of the parties or upon written motion of one of the parties establishing:
1. Extraordinary circumstances, or
2. The possibility of irreparable harm if the hearing is not held sooner.

D. Notice of hearing ~~date~~. The PSA or its designee shall provide notice of the hearing ~~date~~ to the ~~Premium Share~~ member or the authorized representative and to all other parties to the hearing.

E. Continued services. If a request for expedited hearing and a request for continued services is filed in a timely manner under this Section, the ~~Premium Share~~ contractor shall not terminate, reduce, or suspend the service during the expedited hearing process.

F. Previously authorized service.
1. In addition to services which are continued under subsection (E), the ~~Premium Share~~ contractor shall continue services pending a hearing decision if:
   a. The ~~Premium Share~~ contractor denies an authorization for a previously authorized service for the ~~Premium Share~~ member because ~~Premium Share~~ the contractor considers the service new and independent of any previous authorization;
   b. The ~~Premium Share~~ member's primary care physician asserts that the requested service is a necessary continuation of the previous authorization; and
   c. The ~~Premium Share~~ member challenges the denial on this basis and timely requests continued services.
2. Services shall not be continued if:
   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.

G. Financial liability 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. If an expedited hearing is requested, a hearing shall be conducted under A.R.S. § 41-1092.

I. Alternative hearing process. A request for expedited hearing shall be considered a grievance under 9 A.A.C. 30, Article 6, and the PSA shall forward the request to the ~~Premium Share~~ contractor within 10 business days after the day the Administration receives the request if:
1. The Administration determines that a request for hearing filed under this Section is not timely, as determined by the Office of Legal Assistance's date stamp on the document; or
2. The request for hearing does not involve the denial, reduction, suspension, or termination of a service.

R9-30-808. Maintenance of Records

The ~~Premium Share~~ contractor providing notice of denial, reduction, suspension, or termination of a service shall maintain records of the written notification and the date of the notice given to the ~~Premium Share~~ member.

R9-30-809. Member Handbook

A ~~Premium Share~~ contractor shall furnish each ~~Premium Share~~ member with a handbook, as specified in contract, that explains a ~~Premium Share~~ member's right to file a grievance or request a hearing concerning an action that affects a ~~Premium Share~~ member's receipt of medical services.

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) CHILDREN'S HEALTH INSURANCE PROGRAM

PREAMBLE

1. Sections Affected — **Rulemaking Action**

Sections Affected	Rulemaking Action
R9-31-101	Amend
R9-31-112	Amend
R9-31-201	Amend
R9-31-210	Amend
R9-31-1201	Amend
R9-31-1202	Amend
R9-31-1203	Amend
R9-31-1204	Amend
R9-31-1205	Amend
R9-31-1206	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 36-2986(A)

Implementing statute: Laws 2001, Chapter 344

3. The effective date of the rules:

October 1, 2001

4. A list of all previous notices appearing in the Register addressing the exempt rule:

Notice of Rulemaking Docket Opening: 7 A.A.R 2660, June 22, 2001

Notice of Public Meeting on Open Rulemaking Docket: 7 A.A.R. 2960, July 6, 2001

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS, Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from the regular rulemaking procedures:

Laws 2001, Ch. 344 § 113 exempts the Administration from the rulemaking requirements of A.R.S. Title 41, Ch. 6. The Administration amended three of the 16 Articles in 9 A.A.C. 31 to comply with recent statutory changes made by Laws of 2001, Ch. 344 and to provide additional clarification to the rule language.

7. A reference to any study that the agency relied on in its evaluation of or justification for the rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

Not applicable

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

Not applicable

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

Not applicable

A summary of the principal comments and the agency response to them:

No comments were received.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

13. Incorporations by reference and their location in the rules:

None

14. Was this rule previously adopted as an emergency rule? If so, please indicate the Register citation:

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) CHILDREN'S HEALTH INSURANCE PROGRAM

ARTICLE 1. DEFINITIONS

Section
R9-31-101. Location of Definitions
R9-31-112. Covered Behavioral Health Services Related Definitions

ARTICLE 2. SCOPE OF SERVICES

Section
R9-31-201. General Requirements
R9-31-210. Emergency Medical Services

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

Section
R9-31-1201. General Requirements
R9-31-1202. ADHS and ~~Health Plan~~ Contractor Responsibilities
R9-31-1203. Eligibility for Covered Services
R9-31-1204. General Service Requirements
R9-31-1205. Scope of Behavioral Health Services
R9-31-1206. General Provisions and Standards for Service Providers

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
~~"1st-party" liability"~~	~~R9-22-110~~
~~"3rd-party"~~	R9-22-110
~~"3rd-party liability"~~	~~R9-22-110~~
"Accommodation"	R9-22-107
"Action"	R9-31-113
"Acute mental health services"	R9-22-112
"ADHS"	R9-31-112
"Administration"	A.R.S. § 36-2901
"Adverse action"	R9-31-108
"Aggregate"	R9-22-107
"AHCCCS"	R9-31-101
"Ambulance"	R9-22-102
"Ancillary department"	R9-22-107

Term	Location
"Applicant"	R9-31-101
"Application"	R9-31-101
~~"ADHS"~~	~~R9-31-112~~
"Behavior management ~~services"~~ service"	R9-31-112
~~"Behavioral health paraprofessional"~~	~~R9-31-112~~
"Behavioral health evaluation"	R9-31-112
"Behavioral health medical practitioner"	R9-31-112
"Behavioral health professional"	R9-31-112
"Behavioral health service"	R9-31-112
"Behavioral health technician"	R9-31-112
"Billed charges"	R9-22-107
~~"Board eligible~~ "Board-eligible for psychiatry"	R9-31-112
"Capital costs"	R9-22-107
~~"Case management services"~~	~~R9-22-112~~
"Certified nurse practitioner"	R9-31-102
"Certified psychiatric nurse practitioner"	R9-31-112
"Child"	42 U.S.C. 1397jj
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-31-112
"CMDP"	R9-31-103
"Continuous stay"	R9-22-101
"Contract"	R9-22-101
"Contractor"	R9-31-101
"Contract year"	R9-31-101
"Copayment"	R9-22-107
"Cost avoidance"	R9-31-110
"Cost-to-charge ratio"	R9-22-107
"Covered charges"	R9-31-107
"Covered services"	R9-22-102
"CPT"	R9-22-107
"CRS"	R9-31-103
"Date of action"	R9-31-113
"Day"	R9-22-101
"Denial"	R9-31-113
"De novo hearing"	R9-31-112
"Dentures"	R9-22-102
"DES"	R9-31-103
"Determination"	R9-31-103
"Diagnostic services"	R9-22-102
"Director"	A.R.S. § 36-2981
"DME"	R9-22-102
"DRI inflation factor"	R9-22-107
~~"EAC"~~	~~A.R.S. § 36-2905.03(B)~~
~~"ELIC"~~	~~A.R.S. § 36-2905.03(C) and (D)~~
"Emergency medical condition"	~~42 U.S.C. 1396(v)~~ 42 U.S.C. 1396b(v)
"Emergency medical services"	R9-22-102
"Encounter"	R9-22-107
"Enrollment"	R9-31-103
~~"Evaluation"~~	~~R9-31-112~~
"Facility"	R9-22-101
"Factor"	R9-22-101
"First-party liability"	R9-22-110
"FPL"	A.R.S. § 36-2981
"Grievance"	R9-22-108
"Group Health Plan"	42 U.S.C. 1397jj
"GSA"	R9-22-101
"Guardian"	R9-22-103
"Head of Household"	R9-31-103

“Health care practitioner”	R9-31-112
“Health plan”	A.R.S. § 36-2981
“Hearing”	R9-22-108
“Hearing aid”	R9-22-102
“Home health services”	R9-22-102
“Hospital”	R9-22-101
“Household income”	R9-31-103
“ICU”	R9-22-107
“IGA”	R9-31-116
“IHS”	R9-31-116
“IHS” or “Tribal Facility Provider”	R9-31-116
“IMD”	R9-31-112
“Inmate of a public institution”	42 CFR 435.1009
“Inpatient hospital services”	R9-31-101
~~“Inpatient psychiatric facilities for individuals under age 21~~	~~R9-31-112~~
“License” or “licensure”	R9-22-101
“Medical record”	R9-22-101
“Medical review”	R9-31-107
“Medical services”	R9-22-101
“Medical supplies”	R9-22-102
“Medically necessary”	R9-22-101
“Member”	A.R.S. § 36-2981
“Mental disorder”	R9-31-112
~~“MI/MN”~~	~~A.R.S. § 36-2901(4)(a) and (c)~~
“New hospital”	R9-22-107
“NF”	42 U.S.C. 1396r(a)
“NICU”	R9-22-107
“Noncontracting provider”	A.R.S. § 36-2981
“Occupational therapy”	R9-22-102
“Offeror”	R9-31-106
“Operating costs”	R9-22-107
“Outlier”	R9-31-107
“Outpatient hospital service”	R9-22-107
“Ownership change”	R9-22-107
“Partial care”	R9-31-112
“Peer group”	R9-22-107
“Pharmaceutical service”	R9-22-102
“Physical therapy”	R9-22-102
“Physician”	A.R.S. § 36-2981
“Post stabilization services”	42 CFR 438.114
“Practitioner”	R9-22-102
“Pre-existing condition”	R9-31-105
“Prepaid capitated”	A.R.S. § 36-2981
“Prescription”	R9-22-102
“Primary care physician”	A.R.S. § 36-2981
“Primary care practitioner”	A.R.S. § 36-2981
“Primary care provider”	R9-22-102
“Primary care provider services”	R9-22-102
“Prior authorization”	R9-22-102
“Private duty nursing services”	R9-22-102
“Program”	A.R.S. § 36-2981
“Proposal”	R9-31-106
“Prospective rates”	R9-22-107
“Prudent layperson standard”	42 U.S.C. 1396u-2
“PSP”	R9-31-103
“Psychiatrist”	R9-31-112
“Psychologist”	R9-31-112
“Psychosocial rehabilitation”	R9-31-112

“Qualified alien”	P.L. 104-193
“Qualifying Health Center”	~~A.R.S. § 36-2981~~ A.R.S. § 2907.06
“Qualifying plan”	A.R.S. § 36-2981
“Quality management”	R9-22-105
“Radiology services”	R9-22-102
“RBHA”	R9-31-112
“Rebasing”	R9-22-107
“Redetermination”	R9-31-103
“Referral”	R9-22-101
~~“RBHA”~~	~~R9-31-112~~
“Registered nurse”	R9-31-112
“Rehabilitation services”	R9-22-102
“Reinsurance”	R9-22-107
“RFP”	R9-31-106
“Respiratory therapy”	R9-22-102
“Respondent”	R9-22-108
“Scope of services”	R9-22-102
~~“Screening”~~	~~R9-31-112~~
“SDAD”	R9-22-107
~~“SMI”~~	~~A.R.S. § 36-550~~
“Service location”	R9-22-101
“Service site”	R9-22-101
“SMI”	A.R.S. § 36-550
“Specialist”	R9-22-102
“Speech therapy”	R9-22-102
“Spouse”	R9-31-103
“SSI-MAO”	R9-31-103
“Sterilization”	R9-22-102
“Subcontract”	R9-22-101
~~“Substance abuse”~~	~~R9-31-112~~
~~“TRBHA”~~	~~R9-31-116~~
“Third-Party”	R9-22-110
“Third-Party liability”	R9-22-110
“Tier”	R9-22-107
“Tiered per diem”	R9-31-107
“Title XIX”	42 U.S.C. 1396
“Title XXI”	~~42 U.S.C. 1397jj~~ 42 U.S.C. 1397aa
~~“Treatment”~~	~~R9-31-112~~
“TRBHA”	R9-31-116
“Tribal facility”	A.R.S. § 36-2981
“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:

“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.

“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.

“Application” means an official request for Title XXI benefits made in accordance with Article 3.

“Contractor” means a health plan that contracts with the Administration for the provision of hospitalization and medical care to members under the provisions of this Article or a qualifying plan.

“Contract year” means the date beginning on October 1 and continuing until September 30 of the following year.

“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.

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, the agency mandated to serve the public health needs of all Arizona residents.

~~2. “Behavior management services” specified in 9 A.A.C. 20.~~

“Behavior management service” means those services that assist the member in carrying out daily living tasks and other activities essential for living in the community.

“Behavioral health evaluation” means the assessment of a member’s medical, psychological, psychiatric, or social condition to determine if a behavioral health disorder exists and, if so, to establish a treatment plan for all medically necessary services.

~~3. “Behavioral health paraprofessional” defined in 9 A.A.C. 20, Article 1.~~

“Behavioral health medical practitioner” means a health care practitioner with at least one year of full-time behavioral health work experience.

~~4.~~ “Behavioral health professional” defined in ~~9 A.A.C. 20 Article 1~~. 9 A.A.C. 20.

~~5.~~ “Behavioral health ~~services” defined in 9 A.A.C. 20, Article 1.~~ service” means those services provided for the evaluation and diagnosis of a mental health or substance abuse condition, and the planned care, treatment, and rehabilitation of the member.

~~6.~~ “Behavioral health technician” defined in ~~9 A.A.C. 20, Article 1.~~ 9 A.A.C. 20.

~~7.~~ “Board-eligible for psychiatry” means completion of an accredited psychiatry residency program approved by the American College of Graduate Medical Education, or the American Osteopathic Association~~. Documentation of completion of a residency program includes a certificate of residency training including exact dates of residency, or a letter of verification of residency training from the training director including the exact dates of training period~~ defined in 9 A.A.C. 22, Article 1.

~~8. “Case management services” means supportive services and activities that enhance treatment, compliance, and effectiveness of treatment. This definition shall only be applicable for purposes of Article 12.~~

~~9.~~ “Certified psychiatric nurse practitioner” ~~as specified in A.R.S. § 32-1601 and certified under the American Nursing Association’s Statement and Standards for Psychiatric-Mental Health Clinical Nursing Practice under A.A.C. R4-19-505.~~ defined in 9 A.A.C. 22, Article 1.

~~10.~~ “Clinical supervision” specified in ~~9 A.A.C. 209.~~ A.A.C. 22, Article 1.

~~11.~~ “De novo hearing” defined in ~~42 CFR 431.202.~~ 42 CFR 431.201.

~~12. “Evaluation” means the initial assessment of a member’s medical, psychological, psychiatric, or social condition to determine if a behavioral health disorder exists and, if so, to establish a treatment plan for all medically necessary services.~~

“Health care practitioner” means a:

Physician;

Physician assistant;

Nurse practitioner; or

Other individual licensed and authorized by law to dispense and prescribe medication and devices, as defined in A.R.S. 32-1901.

~~13.~~ “IMD” ~~means an Institution for Mental Diseases as described in 42 CFR 435.1009 and licensed by ADHS.~~ defined in 9 A.A.C. 22, Article 1.

~~14. “Inpatient psychiatric facilities for individuals under age 21” means a licensed hospital or a psychiatric hospital or a Residential Treatment Center (RTC) licensed as a Level I behavioral health facility by ADHS and accredited by an AHCCCS approved accrediting body as specified in contract and authorized by federal law or regulations. These facilities provide room and board and treatment for behavioral health problems of an individual who is under 21 years of age.~~

~~15.~~ “Mental disorder” defined in A.R.S. § 36-501.

~~16.~~ “Partial Care” ~~means:~~ defined in 9 A.A.C. 22, Article 1.

~~a. “Basic partial care” specified in 9 A.A.C. 20.~~

~~b. “Intensive partial care services” specified in 9 A.A.C. 20.~~

~~17.~~ “Psychiatrist” specified in A.R.S. §§ 32-1401 or 32-1800 and 36-501.

~~18.~~ “Psychologist” specified in A.R.S. §§ 32-2061 and 36-501.

~~19.~~ “Psychosocial rehabilitation” ~~specified in 9 A.A.C. 20~~ defined in 9 A.A.C. 22, Article 1.

~~20.~~ “RBHA” means the Regional Behavioral Health Authority defined in ~~9 A.A.C. 21, Article 1.~~ A.R.S. § 36-3401.

~~21. “Screening” means a face-to-face interaction with a member to determine the need for behavioral health services and the referral of the member for further evaluation, diagnosis, or care and treatment.~~

~~22. “Substance abuse” defined in 9 A.A.C. 20, Article 1.~~

~~23. “Treatment” defined in 9 A.A.C. 20, Article 1.~~

ARTICLE 2. SCOPE OF SERVICES

R9-31-201. General Requirements

A. The Administration shall administer the program ~~specified in~~ under 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~~ under A.R.S. § 36-2986.
C. Behavioral health services shall be provided ~~as specified in~~ under 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~~ Under 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 under 42 CFR 435.1009,
   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 an NF 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.

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~~ under 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 ~~an~~ 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~~ seven 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~~ Behavioral Health Evaluation 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,~~ Providers 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~~ under 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,~~ provider 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.~~ under 42 CFR 438.114.

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

R9-31-1201. General Requirements

General requirements. The following general requirements apply to behavioral health services provided under this Article, subject to all exclusions and limitations.

1. Administration. The program shall be administered as specified in A.R.S. § 36-2982.
2. Provision of services. Behavioral health services shall be provided as specified in A.R.S. § 36-2989 and this Chapter.
3. Definitions. The following definitions apply to this Article:
   - ~~a. "Alternative Residential Care Facility" means an ADHS-licensed facility with 16 or fewer beds. Alternative residential care facilities include Level I facilities licensed to provide emergency services, or detoxification services, or Level II and III facilities.~~
   - ~~b. "Emergency or crisis behavioral health services" as specified in 9 A.A.C. 20.~~
   - ~~c. "Health plan" means a plan that contracts directly with AHCCCS to provide services specified by contract and this Article.~~
   - ~~d. "IMD" means an Institution for Mental Diseases which is a facility as described in 42 CFR 435.1009 and licensed by ADHS.~~
   - ~~e. "Physician assistant" specified in A.R.S. § 32-2501. In addition, a physician assistant providing a behavioral health service shall be supervised by an AHCCCS-registered psychiatrist.~~
   - ~~f. "TRBHA" means the Tribal Regional Behavioral Health Authority.~~
   - a. "Case management services" defined in 9 A.A.C. 22, Article 12.
   - b. "Health plan" means a "Contractor" as defined in A.R.S. § 36-2901.
   - c. "Physician assistant" specified in A.R.S. § 32-2501. In addition, a physician assistant providing a behavioral health service shall be supervised by an AHCCCS-registered psychiatrist.
   - d. "Respite" defined in 9 A.A.C. 22, Article 12.
   - e. "Substance abuse" defined in 9 A.A.C. 22, Article 12.
   - f. "TRBHA" means the Tribal Regional Behavioral Health Authority.
   - g. "Therapeutic foster care services" defined in 9 A.A.C. 22, Article 12.

R9-31-1202. ADHS and ~~Health Plan~~ Contractor Responsibilities

A. ADHS responsibilities. Behavioral health services shall be provided by ~~an~~ a RBHA through a contract with ADHS. ADHS shall:

1. Contract with ~~an~~ a RBHA for the provision of behavioral health services in R9-31-1205 for all Title XXI members as specified in A.R.S. § 36-2989. ADHS shall ensure that ~~an~~ a RBHA provides behavioral health services directly to members or through subcontracts with qualified service providers who meet the qualifications specified in R9-31-1206. If behavioral health services are unavailable within ~~an~~ a RBHA's service area, ADHS shall ensure that ~~an~~ a RBHA provides behavioral health services outside the service area.
~~2. Diagnose and evaluate a child who may be in need of behavioral health services, for an eligibility determination, and who is not already enrolled with Title XXI under A.R.S. § 36-2986.~~
~~3.~~2. Ensure that a member's behavioral health service is provided in collaboration with a member's primary care provider.
~~4.~~3. Coordinate the transition of care and medical records, as specified in A.R.S. §§ 36-2986, 36-509, A.A.C. R9-31-512, and in contract, when a member transitions from:
   a. A behavioral health provider to another behavioral health provider,
   b. ~~An~~ A RBHA to another RBHA,
   c. ~~An~~ A RBHA to a ~~health plan~~ contractor,
   d. ~~An~~ A ~~health plan~~ contractor to a RBHA, or
   e. ~~An~~ A ~~health plan~~ contractor to another ~~health plan~~ contractor.

B. ADHS may contract with a TRBHA for the provision of behavioral health services for Native American members. In the absence of a contract with ADHS, Native American members may:
1. Receive behavioral health services from an IHS facility or a TRBHA, or
2. Be referred off-reservation to ~~an~~ a RBHA for covered behavioral health services.

C. ~~Health plan~~ Contractor responsibilities. A ~~health plan~~ contractor shall:
1. Refer a member to ~~an~~ a RBHA according to the contract terms;
2. Provide inpatient emergency behavioral health services specified in R9-31-1205 for a member not yet enrolled with ~~an~~ a RBHA;
3. Provide psychotropic medication services for a member, in consultation with the member's RBHA as needed, for behavioral health conditions that are specified in contract within the primary care provider's scope of practice; and
4. Coordinate a member's transition of care and medical records specified in R9-31-1202.

D. ADHS, its subcontractors and AHCCCS acute care ~~health plans~~ contractors shall cooperate as specified in contract when a transition from ~~1~~ 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.~~

R9-31-1203. Eligibility for Covered Services

A. Eligibility for covered services. A member determined eligible ~~according to~~ under A.R.S. § 36-2981 shall receive medically necessary covered services specified in R9-31-1205.

B. Ineligibility. A person is not eligible for behavioral health services if the person is:
1. An inmate of a public institution as defined in 42 CFR 435.1009;
2. A resident of an institution for the treatment of tuberculosis; or
3. In an institution for ~~the treatment of~~ mental diseases at the time of ~~application, or at the time of redetermination~~. application.

R9-31-1204. General Service Requirements

A. Services. Behavioral health services include both mental health and substance abuse services.

B. Medical necessity. A service shall be medically necessary ~~as specified in~~ under R9-31-201.

C. Prior authorization. A service shall be provided by contractors, subcontractors, and providers consistent with the prior authorization requirements established by the Director and ~~specified in~~ under R9-31-210 and R9-31-1205.

D. Experimental services. The Director shall determine if a service is experimental, or whether a service is provided primarily for the purpose of research. Those services shall not be covered.

E. Gratuities. A service or an item, if furnished gratuitously to a member, is not covered and payment shall be denied to a provider.

F. Service area. Behavioral health services rendered to a member shall be provided within the RBHA's service area except when:
1. A ~~health plan's~~ contractor's primary care provider refers a member to another area for medical specialty care,
2. A member's medically necessary covered service is not available within the service area, or
3. A net savings in behavioral health service delivery costs can be documented by the RBHA for a member. Undue travel time or hardship shall be considered for a member or a member's family.

G. Travel. If a member travels or temporarily resides out of a behavioral health service area, covered services are restricted to emergency behavioral health care, unless otherwise authorized by a member's RBHA.

H. Non-covered services. If a member requests a behavioral health service that is not covered by Title XXI or is not authorized by an a RBHA, the behavioral health service may be provided by an AHCCCS-registered behavioral health service provider under the following conditions:

1. The requested service and the itemized cost of each service is documented and provided to the member or member's guardian; and
2. The member or member's guardian signs a statement acknowledging:
   a. Services have been explained to the member or member's guardian, and
   b. Member or member's guardian accepts responsibility for payment.

I. Referral. If a member is referred out of ~~an~~ a RBHA's service area to receive an authorized medically necessary behavioral health service or a medically necessary covered service the service shall be provided by the ~~health plan~~ contractor or RBHA. Behavioral health services shall be provided with the limitations specified in R9-31-1205.

J. Restrictions and limitations. ~~The restrictions, limitations, and exclusions in this Article shall not apply to a health plan or an RBHA when electing to provide a noncovered service.~~
1. The restrictions, limitations, and exclusions in this Article shall not apply to a contractor or a RBHA when electing to provide a noncovered service.
2. Room and board is not a covered service unless provided in an inpatient, sub-acute, or residential treatment center under R9-31-1205.

~~**K.** Residential settings. Partial care, outpatient, emergency services, and other behavioral health services shall be covered if medically necessary when provided in a residential setting by a licensed provider. Room and board is not a covered service unless provided in an inpatient facility specified in R9-31-1205(B).~~

R9-31-1205. Scope of Behavioral Health Services

A. Inpatient behavioral health services. The following inpatient services shall be covered subject to the limitations and exclusions in this Article.
1. Inpatient behavioral health services provided in a Medicare (Title XVIII) certified hospital include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment. The behavioral health service shall be provided under the direction of a physician in:
   a. A general acute care ~~hospital;~~ hospital, or
   b. An inpatient psychiatric ~~facility for a person under 21 years of age, licensed as a psychiatric hospital, or a residential treatment center, licensed as a Level I Psychiatric Facility, and accredited by an AHCCCS-approved accrediting body as specified in contract and as authorized by federal law and regulations~~ hospital.
2. Inpatient service limitations:
   a. Inpatient services, other than emergency services specified in this Section, shall be prior authorized.
   b. Inpatient services shall be reimbursed on a per diem basis and shall be inclusive of all services and room and board, except the following may bill independently for services and the services do not count toward the 30-day 30- visit annual limitation:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician ~~assistant as defined in this Article, or~~ assistant,
      iv. A ~~psychologist.~~ psychologist,
      v. A certified independent social worker,
      vi. A certified marriage and family therapist,
      vii. A certified professional counselor, or
      viii. A behavioral health medical practitioner.
   ~~c. The following services may be billed independently if prescribed by a provider specified in R9-31-1205(B)(1)(b) for a member residing in a residential treatment center:~~
      ~~i. Laboratory,~~
      ~~ii. Radiology, and~~
      ~~iii. Psychotropic medications and medication monitoring and medication adjustment.~~
   ~~d.~~c. Title XXI funding for IMD inpatient services is available only to a member who is under 19 years of age. Title XXI funding shall not exceed 30 days inpatient care after an eligibility determination. A member cannot be in an IMD at the time of application or at the time of redetermination.
   ~~e.~~d. Inpatient services are limited to a maximum of 30 days per contract year.

~~**B.** Partial care. The following partial care services shall be covered subject to the limitations and exclusions in this Article.~~
~~1. Partial care shall be provided as either a basic or intensive level of care to:~~
   ~~a. Meet a member's need for behavioral health treatment, and~~
   ~~b. Prevent placing a member in a higher level of care or a more restrictive environment.~~
      ~~i. Basic partial care services shall be provided as specified in 9 A.A.C. 20.~~
      ~~ii. Intensive partial care services shall be provided as specified in 9 A.A.C. 20.~~
~~2. Partial care service limitations. All services shall be included in the partial care reimbursement rate, practitioners may bill independently:~~
   ~~a. A psychiatrist,~~
   ~~b. A certified psychiatric nurse practitioner,~~

~~c. A physician assistant as defined in this Article, and~~
~~d. A psychologist.~~

~~**C.** Outpatient services. The following outpatient services shall be covered subject to the limitations and exclusions in this Article.~~
~~1. Outpatient services shall include the following:~~
~~a. Screening provided by a behavioral health professional or a behavioral health technician;~~
~~b. Evaluation provided by a behavioral health professional;~~
~~c. Counseling including individual therapy, group, and family therapy provided by a behavioral health professional or a behavioral health technician under the clinical supervision of a behavioral health professional;~~
~~d. Behavior management provided by a behavioral health professional, a behavioral health technician, or a behavioral health paraprofessional; and~~
~~e. Psychosocial rehabilitation provided by a behavioral health professional, a behavioral health technician, or a behavioral health paraprofessional.~~
~~2. Outpatient service limitations:~~
~~a. The following practitioners may bill independently:~~
~~i. A psychiatrist,~~
~~ii. A certified psychiatric nurse practitioner,~~
~~iii. A physician assistant as defined in this Article, and~~
~~iv. A psychologist.~~
~~b. Other behavioral health professionals, behavioral health technicians, and behavioral health paraprofessionals not specified in subsection (D)(2)(a) shall be employed by, or contracted with, an AHCCCS-registered behavioral health agency.~~

~~**D.** Behavioral health emergency services. The following emergency services are covered subject to the limitations and exclusions in this Article.~~
~~1. An RBHA shall ensure that behavioral health emergency services are provided by the qualified personnel specified in R9-22-1206. The emergency services shall be available 24 hours-per-day, 7 days-per-week in the RBHA's service area in emergency situations when a member is a danger to self or others or is otherwise determined in need of immediate unscheduled behavioral health services. Behavioral health emergency services may be provided on either an inpatient or outpatient basis.~~
~~2. A health plan shall provide behavioral health emergency services on an inpatient basis not to exceed 3 days per emergency episode and 12 days per contract year, for a member not yet enrolled with an RBHA.~~
~~3. An inpatient emergency service provider shall verify the eligibility and enrollment of a member through the Administration to determine the need for notification to a health plan or an RBHA and to determine the party responsible for payment of services under Article 7.~~
~~4. Behavioral health emergency service limitations:~~
~~a. An emergency behavioral health service does not require prior authorization. The provider shall, however, comply with the notification requirements specified in R9-22-210.~~
~~b. A behavioral health service for an unrelated condition, that requires evaluation, diagnosis, and treatment shall be prior authorized by an RBHA.~~

~~**E.** Other behavioral health services. Other behavioral health services include:~~
~~1. Case management as defined in R9-22-112;~~
~~2. Laboratory and radiology services for behavioral health diagnosis and medication management;~~
~~3. Psychotropic medication and related medication included in a health plan's or an RBHA's formulary; and~~
~~4. Medication monitoring, administration, and adjustment for psychotropic medication and related medications.~~

~~**F.** Transportation services.~~
~~1. Emergency transportation shall be covered for a behavioral health emergency specified in R9-22-211. Emergency transportation is limited to behavioral health emergencies.~~

B. Level I Residential Treatment Center Services. The following Residential Treatment Center services shall be covered subject to the limitations and exclusions in this Article.
1. Level I Residential Treatment Center services shall be provided under the direction of a physician in a Level I Residential Treatment Center accredited by an AHCCCS approved accrediting body as specified in contract.
2. Residential Treatment Center services include room and board and treatment services for mental health and substance abuse conditions.
3. Residential Treatment Center service limitations:
a. Services shall be prior authorized, except for emergency services as specified in this Section.
b. Services shall be reimbursed on a per diem basis and shall be inclusive of all services, except the following may bill independently for services:
i. A psychiatrist,
ii. A certified psychiatric nurse practitioner,

iii. A physician assistant,
iv. A psychologist,
v. A certified independent social worker,
vi. A certified marriage and family therapist,
vii. A certified professional counselor, or
viii. A behavioral health medical practitioner.
c. Title XXI funding for IMD inpatient services is available only to a member who is under 19 years of age. An applicant or member cannot be in an IMD at the time of application or at the time of redetermination.
4. The following services may be billed independently if prescribed by a provider specified in this Section:
a. Laboratory,
b. Radiology, and
c. Psychotropic medication.

C. Level I Sub-acute Facility Services. The following sub-acute facility services shall be covered subject to the limitations and exclusions in this Article.
1. Level I sub-acute facility services shall be provided under the direction of a physician in a Level I sub-acute facility accredited by an AHCCCS approved accrediting body as specified in contract.
2. Level I sub-acute services include room and board and treatment services for mental health and substance abuse conditions.
3. Services shall be reimbursed on a per diem basis and shall be inclusive of all services, except the following may bill independently for services:
a. A psychiatrist,
b. A certified psychiatric nurse practitioner,
c. A physician assistant,
d. A psychologist,
e. A certified independent social worker,
f. A certified marriage and family therapist,
g. A certified professional counselor, or
h. A behavioral health medical practitioner.
4. Title XXI funding for IMD inpatient services is available only to a member who is under 19 years of age. An applicant or member cannot be in an IMD at the time of application or at the time of redetermination.
5. The following services may be billed independently if prescribed by a provider specified in this Section:
a. Laboratory,
b. Radiology, and
c. Psychotropic medication.

D. ADHS licensed Level II Behavioral Health Residential Services. The following Level II Behavioral Health Residential services shall be covered subject to the limitations and exclusions in this Article.
1. Level II Behavioral Health services shall be provided by a licensed Level II agency.
2. Services shall be inclusive of all covered services except room and board.
3. The following may bill independently for services:
a. A psychiatrist,
b. A certified psychiatric nurse practitioner,
c. A physician assistant,
d. A psychologist,
e. A certified independent social worker,
f. A certified marriage and family therapist,
g. A certified professional counselor, or
h. A behavioral health medical practitioner.

E. ADHS licensed Level III Behavioral Health Residential Services. The following Level III Behavioral Health Residential services shall be covered subject to the limitations and exclusions in this Article.
1. Level III Behavioral Health services shall be provided by a licensed Level III agency.
2. Services shall be inclusive of all covered services except room and board.
3. The following may bill independently for services:
a. A psychiatrist,
b. A certified psychiatric nurse practitioner,
c. A physician assistant,
d. A psychologist,
e. A certified independent social worker,
f. A certified marriage and family therapist,
g. A certified professional counselor, or

h. A behavioral health medical practitioner.

F. Partial care. The following partial care services shall be covered subject to the limitations and exclusions in this Article.

1. Partial care shall be provided by an agency qualified to provide a regularly scheduled day program of individual member, group or family activities that are designed to improve the ability of the member to function in the community.
2. Partial care services count toward the 30-day limitation during each contract year. Each full day of partial care, basic or intensive, counts as 1/2 day of inpatient care. Each 1/2 day of partial care, basic or intensive, counts as 1/4 day of inpatient care.
3. Partial care service exclusions. School attendance and educational hours shall not be included as a partial care service and shall not be billed concurrently with these services.

G. Outpatient services. The following outpatient services shall be covered subject to the limitations and exclusions in this Article.

1. Outpatient services shall include the following:
   a. Screening provided by a behavioral health professional or a behavioral health technician;
   b. Initial behavioral health evaluation provided by a behavioral health professional;
   c. Ongoing behavioral health evaluation by a behavioral health professional or a behavioral health technician;
   d. Counseling including individual therapy, group, and family therapy provided by a behavioral health professional or a behavioral health technician;
   e. Behavior management services provided by qualified individuals or agencies as specified in contract; and
   f. Psychosocial rehabilitation services provided by qualified individuals or agencies as specified in contract.
2. Outpatient service limitations:
   a. The following practitioners may bill independently:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant as defined in this Article,
      iv. A psychologist,
      v. A certified independent social worker,
      vi. A certified professional counselor,
      vii. A certified marriage and family therapist,
      viii. A behavioral health medical practitioner,
      ix. A therapeutic foster parent, and
      x. Other AHCCCS registered providers as specified in contract.
   b. Other behavioral health professionals not specified in subsection (G)(2)(a) shall be employed by, or contracted with, an AHCCCS-registered behavioral health agency.
   c. The total number of all outpatient services shall not exceed a maximum of 30 visits during each contract year. Screening performed once every six months shall not count toward the 30-visit maximum.
   d. Each outpatient service except group therapy or group counseling shall count as one visit. Each group therapy or group counseling service shall count as 1/2 a visit.

H. Behavioral health emergency services.

1. A RBHA shall ensure that behavioral health emergency services are provided by qualified personnel specified in R9-31-1206. The emergency services shall be available 24 hours per day, seven days per week in the RBHA's service area in emergency situations where a member is a danger to self or others or is otherwise determined to be in need of immediate unscheduled behavioral health services. Behavioral health emergency services may be provided on either an inpatient or outpatient basis.
2. A contractor shall provide behavioral health emergency services on an inpatient basis not to exceed three days per emergency episode and 12 days per contract year, for a member not yet enrolled with a RBHA.
3. An inpatient emergency service provider shall verify the eligibility and enrollment of a member through the Administration to determine the need for notification to a contractor or a RBHA and to determine the party responsible for payment of services under Article 7.
4. Behavioral health emergency service limitations:
   a. An emergency behavioral health service does not require prior authorization. The provider shall, however, comply with the notification requirements under R9-31-210.
   b. A behavioral health service for an unrelated condition requires diagnosis and treatment shall be prior authorized by a RBHA.
   c. Inpatient service limitations specified in subsection (A) of this Section shall apply to emergency services provided on an inpatient basis.
   d. Emergency or crisis behavioral health services provided on an outpatient basis by a psychiatrist, a certified psychiatric nurse practitioner, a physician assistant, or a psychologist shall not count toward the outpatient service limitations specified in this Section.

I. Other behavioral health services. The following services are covered but are not included in the visit limitations:
1. Case management as under R9-31-1201;
2. Laboratory and radiology services for behavioral health diagnosis and medication management;
3. Psychotropic medication and related medication;
4. Medication monitoring, administration, and adjustment for psychotropic medication and related medications;
5. Respite care;
6. Therapeutic foster care;
7. Personal assistance; and
8. Other support services to maintain or increase the member's self-sufficiency and ability to live outside an institution.

J. Transportation services.
1. Emergency transportation shall be covered for a behavioral health emergency specified in R9-31-211. Emergency transportation is limited to behavioral health emergencies.
2. Non-emergency transportation for a behavioral health service is excluded.

R9-31-1206. General Provisions and Standards for Service Providers

A. Qualified service provider. A qualified behavioral health service provider shall:
1. Be a non-contracting provider or employed by, or contracted in writing with, ~~an~~ a RBHA or a ~~health plan~~ contractor to provide behavioral health services to a member;
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; and
4. Comply with all requirements ~~specified in~~ under Article 5 and this Article.

B. Quality and Utilization management.
1. Service providers shall cooperate with the quality and utilization management programs of ~~an~~ a RBHA, a ~~health plan~~ contractor, ADHS, and the Administration which are stated in R9-31-522 and contract.
2. Service providers shall comply with applicable procedures specified in ~~42 CFR 456, August 23, 1996, 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.~~ 42 CFR 456.