

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 EXEMPT RULEMAKING

TITLE 6. ECONOMIC SECURITY

CHAPTER 13. DEPARTMENT OF ECONOMIC SECURITY STATE ASSISTANCE PROGRAMS

PREAMBLE

- 1. Sections Affected**

Article 7	<u>Rulemaking Action</u>
R6-13-701	Repeal
	Repeal
- 2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statute the rule is implementing (specific):**

Authorizing statute: A.R.S. § 41-1954(A)(3)
Implementing statute: A.R.S. § 46-231
Statute authorizing the exemption: Laws 2002, Ch. 329, § 35
- 3. The effective date of the rule:**

October 20, 2003
- 4. A list of all previous notices appearing in the Register addressing the exempt rule:**

None
- 5. The name and address of agency personnel with whom persons may communicate regarding the rule:**

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- 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 Department is initiating the rulemaking to repeal this rule and replace it with a new Chapter of rules pertaining to the General Assistance Program, at 6 A.A.C. 17. Section 35, subsection (B) of House Bill 2709, Ch. 329, filed in the office of the Secretary of State on June 4, 2002, exempts the Department of Economic Security from the rulemaking requirements of Arizona Revised Statutes Title 41, Chapter 6 for one year from the effective date of the act to enact the requirements of A.R.S. § 46-233, as amended by the act.
- 7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

Not applicable

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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:

For the 12-month period of January 1, 2002 through December 31, 2002, the Department of Economic Security issued \$5,642,266 in General Assistance benefits. The monthly average was \$470,188, and the monthly average case-load was 3029 recipients, receiving an average of \$155.23 in General Assistance benefits. This rulemaking has minimal impact to small business and consumers because the Department is repealing an outdated and inaccurate rule, and replacing it with a Chapter of new rules that accurately explain the Department's current procedures for the General Assistance program.

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

The Department did not make any changes after this proposed rule was released for public comment.

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

The Department held public hearings for this rule on August 12, 2003. The Department did not receive any public comment on this rule.

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 rule:

None

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

No

15. The full text of the rules follows:

TITLE 6. ECONOMIC SECURITY

CHAPTER 13. DEPARTMENT OF ECONOMIC SECURITY
STATE ASSISTANCE PROGRAMS

~~ARTICLE 7. GENERAL ASSISTANCE REPEALED~~

Section

R6-13-701. ~~State General Assistance Program Repealed~~

~~ARTICLE 7. GENERAL ASSISTANCE REPEALED~~

~~R6-13-701. State General Assistance Program Repealed~~

~~A. Unemployability. A person may qualify for the state General Assistance Program (GA) on the basis of unemployability due to medical disability alone, or medical disability in combination with social disability, or as a caretaker for a disabled person.~~

- ~~1. Medical disability is defined as inability to engage in substantial gainful employment by reason of a medically determinable physical or mental impairment which has lasted, or is expected to last, at least 30 continuous days from the date of the GA application.~~
- ~~2. Substantial gainful employment is defined as any work of a nature generally performed for remuneration or profit, involving the performance of significant physical or mental duties, or a combination of both.~~
- ~~3. Social disability is defined as any non-medical impairments or deficiencies — such as advanced age, lack of education, or employment history — which, in combination with medical disability, would further serve to limit employability.~~
- ~~4. For GA eligibility purposes, a person shall be considered unemployable due to disability in a calendar month in which any of the criteria listed in subsection (B) or (C) are met.~~
- ~~5. Provided all eligibility factors are met, assistance shall be granted for months in which any of the unemployability criteria in subsection (B), (C), or (D) are met beginning from the date of application up to and including the full calendar month in which the unemployability ends.~~

~~B. Categorical medical disability. A person is categorically considered to be medically disabled if any of the criteria listed below are met either singly or in combination. If so,~~

- ~~1. The determination of disability can be made by the Family Assistance Administration (FAA) local office; and~~
- ~~2. There is no need to secure further medical verification or to refer the case to the District Medical Consultant (DMC) for a determination; and~~

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3. ~~There is no need to consider social disability factors:~~
 - a. ~~RSDI-Disability. The person is determined by the Social Security Administration (SSA) to be eligible for Retirement, Survivors, Disability Insurance (RSDI) benefits based on disability;~~
 - b. ~~SSI. The person is determined by SSA to be eligible for Supplemental Security Income (SSI) on the basis of disability;~~
 - e. ~~VA. The person is determined by the Veterans Administration (VA) to have at least a 50% disability whether or not service-related;~~
 - d. ~~Drug and alcoholic rehabilitation. The person is residing in a clinic or center and is engaged in a drug-abuse rehabilitation or alcoholic detoxification or rehabilitation program provided that repayment is either required or will be accepted in part or in full by the rehabilitation clinic or center;~~
 - e. ~~Vocational rehabilitation. The person is both~~
 - i. ~~An eligible VR client, and~~
 - ii. ~~Is currently under an Individual Written Rehabilitation Plan (IWRP) of the Arizona state VR Agency;~~
 - f. ~~Hospitalized. The person is hospitalized in any hospital, whether public or private, for any physical or mental ailment;~~
 - i. ~~However, the person is not GA-eligible if the hospital meets the person's basic needs of shelter, food, and medication;~~
 - ii. ~~As an exception to the provision above, a person in a hospital which meets the person's basic needs may receive GA for not more than 3 months if paying rent or mortgage to retain a residence which to return to after release;~~
 - g. ~~Conditional release. The person has been released from a hospital and the physician has imposed work restrictions during a specified recuperation period or certifies the person is permanently disabled;~~
 - h. ~~Termination of employment. The person has been required, either by the employer or by a physician, to terminate employment due to the onset of a disability, and a physician has specified a recuperation period or certifies the person is permanently disabled. Whether the disability is job-related, or whether the person is capable of other employment is immaterial;~~
 - i. ~~Pregnancy. The woman is in her last trimester of pregnancy and does not meet the qualifications for Aid to Families with Dependent Children (AFDC) Pregnancy benefits;~~
 - j. ~~Sheltered workshop. The person is employed in a sheltered workshop, or deemed capable of working only in a sheltered workshop;~~
 - k. ~~Prior certification. The person, at the time of application or reapplication, has in the person's case record a prior certification of disability, either by the Department, SSA, or VA, which is still currently valid. The certification may be for a specified duration, or for permanent disability—so long as it covers the current months for which assistance is requested and received.~~
- C.** ~~Medical and social disability. If a person does not meet any of the categorical criteria in subsection (B) above, the person may qualify for assistance on the basis of at least 1 medical disability, either physical or mental, in combination with 1 or more social disability factors:~~
 1. ~~Medical disability factors. The medical disability factor or factors do not need to be of the same severity as required for categorical eligibility in subsection (B) above but shall constitute the primary cause of the person's unemployability. The medical factors, in combination with the social disability factors, shall cause the person to be unemployable—that is, incapable of engaging in substantial gainful employment.~~
 2. ~~Social disability factors. Any social disability factors, which, in combination with medical disability factors, would further serve to render the person unemployable shall be considered by the Department. These include but are not limited to:~~
 - a. ~~Age;~~
 - b. ~~Education;~~
 - c. ~~Employment history;~~
 - d. ~~English (ability to speak or understand spoken English);~~
 - e. ~~Literacy (ability to read or write English)~~
3. ~~Determinations:~~
 - a. ~~Determinations in this category shall not be made by the FAA local office but only by the District Medical Consultants in consultation with employment and rehabilitation specialists of the Department.~~
 - b. ~~In making these determinations, the Department shall consider whether the person is able to engage in any employment for which the person could qualify, whether the person's last job, or any prior job, or any other job, the person could do within the person's residual capabilities, and which currently exists in the national economy. If so, the person shall be determined employable. If not, he shall be determined unemployable.~~
- D.** ~~Caretakers. A person may qualify for GA as an unemployable caretaker if the person is required to remain in the home to give care to a disabled person. The need for such care shall be verified by a physician.~~
- E.** ~~Homemakers:~~

Notices of Exempt Rulemaking

1. A person may qualify for GA as a disabled homemaker if the person meets any of the criteria listed in subsections (B), (C), or (D) above, irrespective of prior work history.
 2. That is, a person is not disqualified from GA assistance solely because the person has never been employed or self-employed.
- F.** Employment while disabled.
1. A person deemed unemployable shall not be disqualified from assistance solely because the person continues or takes up gainful employment while being considered for or while receiving GA assistance.
 2. Any earnings shall be considered on the budget to determine financial eligibility.
- G.** Acceptance of medical treatment. A person is not required, as a condition of GA eligibility, to accept treatment recommended by examining physicians or medical consultants of the Department.
- H.** Referral to and cooperation with VR.
1. A person is not required, as a condition of GA eligibility, to accept referral to, or cooperate with, Vocational Rehabilitation.
 2. A person may be referred to VR by examining physicians or by medical consultants of the Department, or may voluntarily request referral.
- I.** Application for RSDI or SSI. A person who is found by the Department to meet the disability criteria for RSDI or SSI shall, as a condition of GA eligibility, apply for such benefits.
- J.** Citizenship and alienage. To receive GA a person shall either be a U.S. citizen, or an alien legally admitted for permanent residence, or otherwise residing in the U.S.A. under color of law.
- K.** Arizona residency. To receive GA, a person shall be a resident of Arizona. A resident is a person who:
1. Is residing in Arizona, and
 2. Intends to continue residence in Arizona.
- L.** Social Security Numbers (SSN). As a condition of GA eligibility, a person shall present verification of the person's SSN or apply for an SSN. If for any reason SSA cannot grant an SSN to an SSN applicant, this shall not adversely affect GA eligibility.
- M.** Assets and resources. (Limitations on assets and resources are listed in A.R.S. § 46-233(A)(5))
- N.** Age. GA shall not be granted to any person under age 18. There is no maximum age limit.
- O.** Members of AFDC assistance units. GA shall not be granted to any person who meets the description of an AFDC assistance unit member as defined in R6-13-320(F)(1) and A.A.C. R6-3-407. This same restriction applies regardless of whether the person is AFDC eligible or ineligible for the month.
- P.** Reservation Indians.
1. GA cannot be granted to a reservation Indian residing on the Indian's own or any other Indian reservation. Reservation Indians shall be referred to BIA for assistance.
 2. However, Indians residing off-reservation may receive GA.
- Q.** Redeterminations.
1. A redetermination (review of all eligibility factors subject to change) shall be conducted no less often than once every 6 months counting from the 1st month of eligibility.
 2. However, a review of unemployability factors in subsection (B), (C), or (D) shall be conducted upon the expiration of the certification period as indicated by the physician or the DMC of the Department.
 3. Once it is determined by the Department that a person is unemployable per subsection (B), (C), or (D) for 6 months or more, such a determination shall not be reversed unless it is based upon substantial new evidence not considered by the prior DMC.

NOTICE OF EXEMPT RULEMAKING

TITLE 6. ECONOMIC SECURITY

**CHAPTER 17. DEPARTMENT OF ECONOMIC SECURITY
GENERAL ASSISTANCE PROGRAM**

PREAMBLE

1. Sections Affected

Rulemaking Action

Article 1	New Article
R6-17-101	New Section
R6-17-102	New Section
Article 2	New Article
R6-17-201	New Section
R6-17-202	New Section
R6-17-203	New Section
Article 3	New Article
R6-17-301	New Section
R6-17-302	New Section
R6-17-303	New Section
R6-17-304	New Section
R6-17-305	New Section
R6-17-306	New Section
R6-17-307	New Section
R6-17-308	New Section
Article 4	New Article
R6-17-401	New Section
R6-17-402	New Section
R6-17-403	New Section
R6-17-404	New Section
R6-17-405	New Section
R6-17-406	New Section
R6-17-407	New Section
R6-17-408	New Section
Article 5	New Article
R6-17-501	New Section
R6-17-502	New Section
R6-17-503	New Section
R6-17-504	New Section
R6-17-505	New Section
R6-17-506	New Section
R6-17-507	New Section
Article 6	New Article
R6-17-601	New Section
R6-17-602	New Section
R6-17-603	New Section
R6-17-604	New Section
R6-17-605	New Section
R6-17-606	New Section
Article 7	New Article
R6-17-701	New Section
R6-17-702	New Section
R6-17-703	New Section
R6-17-704	New Section
R6-17-705	New Section
R6-17-706	New Section
R6-17-707	New Section
R6-17-708	New Section
R6-17-709	New Section
R6-17-710	New Section
R6-17-711	New Section
Article 8	New Article
R6-17-801	New Section

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R6-17-802	New Section
R6-17-803	New Section
R6-17-804	New Section
R6-17-805	New Section
R6-17-806	New Section
R6-17-807	New Section
Article 9	New Article
R6-17-901	New Section
R6-17-902	New Section
R6-17-903	New Section
R6-17-904	New Section
R6-17-905	New Section
R6-17-906	New Section
R6-17-907	New Section
R6-17-908	New Section
R6-17-909	New Section
R6-17-910	New Section
R6-17-911	New Section
R6-17-912	New Section
R6-17-913	New Section
R6-17-914	New Section
R6-17-915	New Section
R6-17-916	New Section
R6-17-917	New Section
R6-17-918	New Section
R6-17-919	New Section

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

Authorizing statute: A.R.S. § 41-1954(A)(3)

Implementing statute: A.R.S. § 46-231

Statute authorizing the exemption: Laws 2002, Ch. 329, § 35

3. The effective date of the rules:

October 20, 2003

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

None

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

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

The agency is initiating the rulemaking to amend the current eligibility criteria for the General Assistance Program to comply with state statutory requirements for this program. The rules specify the policies and procedures that the agency employs in determining initial and ongoing eligibility for cash benefits in the General Assistance Program.

Section 35, subsection (B) of House Bill 2709, Ch. 329, filed in the office of the Secretary of State on June 4, 2002, exempts the Department of Economic Security from the rulemaking requirements of Arizona Revised Statutes Title 41, Chapter 6 for one year from the effective date of the act to enact the requirements of A.R.S. § 46-233, as amended by the act.

Notices of Exempt Rulemaking

7. A reference to any study relevant to the rules that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

Not applicable

8. A showing of good cause why the rules are necessary to promote a statewide interest if the rules 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:

For the 12-month period of January 1, 2002 through December 31, 2002, the Department of Economic Security issued \$5,642,266 in General Assistance benefits. The monthly average was \$470,188, and the monthly average case-load was 3029 recipients, receiving an average of \$155.23 in General Assistance benefits. The rule has minimal impact to small business and consumers because it explains current procedures in the General Assistance Program.

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

The Department held public hearings on this rule package on August 12, 2003. Since that time, the Department has made the following changes to the rules.

Section number	Change made
Throughout	Minor typographical and formatting changes.
R6-17-102	<ul style="list-style-type: none"> • In definition of “Acceptable medical source,” deleted “certified” because psychologists are licensed in Arizona. Deleted reference to speech and language pathologists, in response to public comment, and because the list of licensed physicians is illustrative only, and not limiting. Added “licensed psychiatrist” to the illustrative list in response to public comment. • Amended the definition of “homestead property” as follows: “Homestead property” means: a. A home that is owned and occupied by an applicant or recipient, or b. A home that is co-owned by the applicant or recipient and a separated or divorced spouse of the applicant or recipient, and is occupied by the separated or divorced spouse. • In definition of “Request for hearing,” added “verbal,” to allow a verbal request for a hearing. This change is to make it consistent with the rest of the rules, which allow for verbal requests. • Amended the definition of “federal disability benefits” to correct reference from RSDI to SSDI. • Deleted definition of RSDI. • Added definition of SSDI.
Throughout	Changed references from RSDI to SSDI.
R6-17-303	Subsection (D)(2)(b): Removed provision stating that DES may not use a collateral contact to verify certain eligibility factors, in response to public comment, because it is inaccurate and unnecessary.
R6-17-803(C)	In R6-17-803(C), the words “on or before” have been replaced with “by” for clarity.
R6-17-806(B)	Amended to clarify that eligibility ends when federal disability benefits are received, not approved.
Article 9	Changed wording from “oral” to “verbal”
R6-17-903	Added the following provision to subsection (A): “If the person makes a verbal request for hearing, the Department shall reduce the appeal and the stated reasons for the appeal to writing, record the date of the verbal request, and forward the request to the Office of Appeals.” In subsection (C), deleted the words “and the issue on appeal.”
R6-17-907	Subsection (C) has been amended to read: “When the Office of Appeals reschedules a hearing under this Section or R6-17-914, the Office of Appeals shall mail the notice of rescheduled hearing at least 11 days prior to the date of the rescheduled hearing.”
R6-17-908	Amended subsection (B)(4) to read: “4. Exclude evidence that is not competent, relevant, or material, or that is unduly repetitious from the record;”

Notices of Exempt Rulemaking

R6-17-910	<ul style="list-style-type: none"> • Subsection (B): Added "...or to otherwise obtain the requested evidence" to allow a party to ask a hearing officer to obtain evidence by other means than a subpoena. • Subsection (C): Inserted a new subsection (5) as follows: "A statement as to the expected substance of the testimony or other evidence, as well as the relevance and importance of the requested testimony or other evidence; and..." and renumbered this subsection. Amended to indicate that the appellant is only required to list the location of an item if the appellant knows the location. • Subsection (F): removed requirement that Department send subpoenas by certified mail, return receipt requested. Department may send subpoenas using regular mail. Added provision allowing Department to subpoena an employee by electronic mail.
R6-17-912	<ul style="list-style-type: none"> • Subsection (A): deleted "or on the open record during the hearing" because it is repetitive. Changed requirement to audiotape withdrawal from "shall" to "may," because local offices do not have the resources to audiotape withdrawals. • Subsection (B): Amended to read: "B. The Office of Appeals shall dismiss the appeal upon receipt of a withdrawal request signed by the appellant or the appellant's representative, or a statement of withdrawal made on the record, when the hearing officer has accepted the withdrawal," to clarify that the hearing officer must accept the withdrawal before the appeal is dismissed.
R6-17-913	<p>Amended subsection (D) as follows: "The hearing officer shall set the matter for a hearing to determine whether the appellant had good cause for the appellant's failure to appear." Amended subsection (F) to expand definition of good cause.</p>
R6-17-914	<ul style="list-style-type: none"> • Subsection (D): Removed the word "tape" so that the Department can record the hearing digitally. Removed "...or record the hearing by other stenographic means..." because it is no longer necessary. • Subsection (F): Added the following: "...provided that such transcription does not delay or interfere with the hearing. The Department's recording of the hearing shall constitute the official record of the hearing," to clarify current procedure. • Subsection (I): Deleted the following: "Unless the hearing officer allows a longer period of time, a statement shall not exceed 3 minutes..." because it is unnecessary. • Subsection (K): Deleted "...and shall exclude any irrelevant evidence..." because it is unnecessary.

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

The Department received comments from Eddie Sissons at the William E. Morris Institute for Justice, Lydia Glasson at Southern Arizona Legal Aid, Mike Bell at St. Vincent DePaul, and Sherry Whitener at Advocates for the Disabled. The comments and responses are summarized below.

Comment	DES Response
References to RSDI are incorrect, and should be SSDI instead.	The Department agrees with this comment and has amended the rules accordingly.
The proposed rules are an unnecessary codification of the policy manual into regulations, which is an overzealous interpretation of the law, and will place undue burdens on potential applicants.	A.R.S. § 41-1003 requires DES to "make practice setting forth the nature and requirements of all formal procedures available to the public." The Department believes that the proposed rules comply with this statute. The Department also believes that it is extremely important to provide its clients and stakeholders with complete and accurate information about how to obtain benefits from the General Assistance program.

Notices of Exempt Rulemaking

Comment	DES Response
<p>R6-17-102: Psychologists are licensed and not certified in Arizona.</p> <p>The proposed regulations fail to provide how a qualified speech and language pathologist is identified.</p> <p>Why is the Department using the term “assistance unit” since that is a Cash Assistance term?</p> <p>In subsection (42), applicants should be able to request a hearing verbally.</p> <p>Psychiatrists and nurse practitioners should be added to the definition of “acceptable medical source.”</p> <p>The definition of “homestead property” is confusing. Does it refer to property that is only co-owned and occupied with the applicant or the recipient? Certainly property that is co-owned and occupied by the divorced or separated spouse with someone other than the applicant or recipient should not have an effect on the applicant or recipient’s eligibility.</p> <p>There is no statutory authority for the term “social disability” as defined in this subsection.</p>	<p>The Department has removed the word “certification” from the definition.</p> <p>The Department has removed speech and language pathologist from the list, because the list is illustrative, not limiting.</p> <p>The Department is using “assistance unit” because the income and resources of the applicant’s spouse may also be considered. If the Department eliminated usage of “assistance unit” in these rules, it would need to be replaced with, “the applicant and the applicant’s spouse, if applicable.”</p> <p>The Department has made the requested change.</p> <p>The Department has added licensed psychiatrist to the list. The Department has not added nurse practitioner, because a nurse practitioner is not a licensed physician.</p> <p>The Department has amended the definition as follows: “Homestead property” means: a. A home that is owned and occupied by an applicant or recipient, or b. A home that is co-owned by the applicant or recipient and a separated or divorced spouse of the applicant or recipient, and is occupied by the separated or divorced spouse.</p> <p>The term “social disability” comes from the SSI disability determination guide published by the SSA. It provides an additional means for an applicant to qualify for GA benefits, and is therefore to the applicant’s benefit.</p>
<p>In R6-17-201(B), there is no statutory authority for a social disability.</p> <p>The definition needs to be consistent with the statutory definition at A.R.S. § 46-233(A)(7), which also allows an expectation of death. This definition is also inconsistent with R6-17-406(C)(3).</p>	<p>The term “social disability” comes from the SSI disability determination guide published by the SSA.</p> <p>The Department believes that the expectation of death issue is sufficiently addressed in R6-17-201(A). The Department does not agree that R6-17-201 is inconsistent with R6-17-406(C)(3), as the two Sections are intended to supplement and complement each other.</p>
<p>R6-17-303(D)(2) is awkwardly worded and confusing. Including the term “relationship of household members” as information that an applicant or recipient cannot verify by statement is unreasonable. How would an applicant obtain collateral or documented proof that a person who lives in their household is a roommate and not related to the applicant? If the Department requires birth or marriage certificates or an equivalent from a collateral source, why not state such?</p> <p>In certain situations, an applicant may not be able to produce documents to verify things that the Department does not allow to be self-affirmed in writing by the applicant. Not allowing an applicant or recipient to state his/her own household expenses could be difficult as there is most likely no documented or collateral proof of some expenses such as food.</p>	<p>The Department has eliminated the provision in R6-17-303(D)(2)(b) stating that DES may not use a collateral contact to verify certain eligibility factors, in response to public comment, because it is inaccurate and unnecessary.</p> <p>The Department cannot accept a written affirmation from the applicant of the items listed in R6-17-303(D)(2)(c)(i)-(vii) because of the potential for fraud.</p>

Notices of Exempt Rulemaking

Comment	DES Response
<p>R6-13-304 should be moved in front of R6-13-303 to emphasize the Department's commitment to customer service.</p> <p>The Department should make sure that the policy manual requires eligibility workers to offer assistance in other benefit areas such as AHCCCS, lifeline, and Food Stamps.</p>	<p>The Department has attempted to organize these rules chronologically. Because the client must attend the interview to initiate the Department's responsibilities at the interview, the Department believes that the current order is appropriate.</p> <p>The policy manual currently contains this requirement.</p>
<p>In R6-17-305, where is the authority for the Department to take up to 60 days to determine eligibility? How is this a budget savings, because eligible applicants receive benefits retroactively to the date of eligibility? One comment indicated that the period should be shortened to 30 days, and that FAA offices are taking the entire 60 day period to decide on an applicant and issue benefits.</p>	<p>R6-17-305 is not a new rule for the GA program. R6-13-202 also provides that the program may take up to 60 days to determine eligibility. (This rule will be amended at a later date to remove references to the GA program.) At the end of Fiscal Year '03, the Department issued a policy directive that required eligibility determinations to be extended to take the entire 60 day period, to accommodate a budget shortfall in that year. Because this is no longer necessary, the Department will rescind that policy directive effective 9/1/03.</p>
<p>R6-17-307, in (B)(1) and (3), the requirement for an applicant to obtain a court order or permission of OSI to review certain materials in the applicant's file denies the applicant the right to information that affects their application and appeals rights. The requirement to obtain a court order is too high of a barrier, and doesn't allow the individual the ability to correct any errors. The requirement to consult with a physician is another excessive barrier to the individual obtaining information from the applicant's file.</p> <p>If the "confidential" information is the basis for an adverse action decision, it must be made available to the applicant/recipient to comply with due process principles. Further, OSI should not be granted authority over GA applicants/recipients through administrative regulations without due process assurances.</p> <p>An applicant or recipient's authorized representative should be allowed to review the contents of the applicant or recipient's case record.</p>	<p>The Department's provisions regarding confidentiality are intended to protect both the applicant or recipient, and the source of any information the Department receives to protect the program against fraud. Medical information may be withheld until a physician informs the Department that the information can be safely released, which is important when, for example, a patient is not yet aware of his or her own diagnosis. The rules contain provisions for accessing all confidential information in the applicant's file, but certain types of information do require a higher level of protection.</p> <p>The Department is required by these rules to inform an applicant or recipient why an adverse action is being taken, but may elect not to inform the individual how the information was obtained, in order to protect the source of the information. OSI is contained within DES and is subject to the same due process requirements as the Department.</p> <p>The Department will allow any individual to review the contents of the applicant's case record if the applicant authorizes the Department to do so, as specified in subsection (C).</p>
<p>Referring to R6-17-405: Where is the statutory authority to preclude American Indians living on a reservation? The provisions of A.R.S. § 46-234 would govern, so it is unnecessary to put it in the rules.</p>	<p>The Department included this provision in the rules because the statutory provision does not adequately explain it. Native Americans are eligible for a different type of assistance through the Bureau of Indian Affairs.</p>
<p>In R6-17-406, why is there a specific listing of various medical conditions?</p> <p>The form used to implement this rule needs to be amended to reflect different types of terminal illnesses.</p> <p>The definition of disability in this Section is inconsistent with statute and R6-17-201(B).</p>	<p>This rule mirrors Social Security standards for determining eligibility for SSI. Individuals having one of the listed conditions do not have to meet the requirements in subsections (1) or (2), meaning that they don't have to have a physical or mental impairment lasting for 12 months or expected to result in death. If the applicant has, for example, a brain tumor that will be removed in 4 months, the applicant would still be considered disabled. If the Department removed the specific conditions listed, that applicant would not be considered disabled, because the condition would resolve in under 12 months and is not expected to result in death.</p> <p>The Department will re-evaluate the form to address this concern.</p> <p>Please see response to comment on R6-17-201(B) above.</p>

Notices of Exempt Rulemaking

Comment	DES Response
<p>In R6-17-408(B), a very large percentage of SSI and SSDI applications are denied at the initial stage and are won on appeal. Caregivers should be able to receive GA while the disabled person's appeal is pending.</p> <p>In subsection (C), to whom does "disabled individual" refer? It should state that if the GA recipient's disability application is denied and this denial is appealed, the GA recipient may receive up to 6 months of cash benefits.</p>	<p>R6-17-408(C) addresses this situation, and allows a GA caretaker to receive benefits for up to 6 months while the appeal is pending. Under R6-17-102(41), "recipient" is defined as a person, including a GA caretaker, who receives GA benefits.</p> <p>"Disabled individual" means either the disabled GA recipient or the disabled person for whom the GA caretaker is providing care.</p>
<p>In R6-17-605, under what basis is a \$24 deduction for work expenses allowed? Wouldn't the spouse receive greater assistance if she or he were classified as a "caretaker" rather than attempting to work?</p> <p>The work expense deduction should be higher. What is the rationale for continuing to limit it to \$24?</p>	<p>The Department does not want to assume that the spouse of a disabled person would not want to work, and believes that the \$24 work expense deduction from countable income should be allowed to support those individuals who do choose to continue employment in lieu of becoming full-time caretakers.</p> <p>The Department is not increasing the work expense deduction at this time, but will consider increasing it in the future.</p>
<p>In R6-17-606, under what basis has the Department established the A-1 and A-2 standard for use with the General Assistance Program.</p>	<p>The Department uses this standard to align with the Cash Assistance Program. If the Department eliminates this standard, it would either:</p> <p>(1) A lower the GA benefit that is uniform for all recipients, or</p> <p>(2) A higher GA benefit level that could require the program to implement a waiting list due to a funding shortfall.</p>
<p>In R6-17-711(C), in some cases, an overpayment might not occur in the 13th month if the recipient received 12 months of GA and is eligible for a 6-month extension of GA. Further, a person could lose GA eligibility during the initial 12 month period prior to the 12th month, due to a denial of his or her disability application. Under these circumstances, if the denial is appealed, the person may qualify for an additional 6 months of GA, which may or may not total 18 months of GA in a 36 month period. Thus, charging an overpayment starting with the issuance of the 13th payment may be improper in some cases.</p>	<p>This rule does not say that any payment in the 13th month is automatically classified as an overpayment. If a recipient meets the criteria at R6-17-806, the recipient can receive an additional 6 months of benefits after the initial 12 months of benefits. Those situations are not classified as an overpayment in the 13th month.</p>
<p>In R6-17-801, where is the authority to require GA eligibility to be reviewed every 6 months?</p>	<p>These rules provide the Department with the authority to review GA eligibility every 6 months. The Department has opted to review eligibility every 6 months to follow up on the applicant's application for federal disability benefits.</p>
<p>In R6-17-803(C), the words, "on or before" should be replaced with "by."</p>	<p>The Department has made this change.</p>
<p>In R6-17-806(B), eligibility for the 6-month extension should end when the federal disability benefits are paid, not approved. It could take several months for a recipient to actually receive payment.</p>	<p>The Department agrees, and has amended the rule accordingly.</p>

Notices of Exempt Rulemaking

Comment	DES Response
<p>In R6-17-903(A), applicants should be allowed to request hearings by telephone. The Department representative should complete the hearing request form if the request for a hearing is made by phone.</p> <p>In subsection (C), the applicant or recipient should not be required to identify the issue on appeal to perfect the appeal. An applicant or recipient may misidentify the issue or may not understand the issue that affects their right to GA benefits. The Department should be required to assist the applicant or recipient in identifying the reason for the appeal. Further, in the definition of a request for hearing at R6-17-102(42), only a desire to present the case or issue to a higher authority is required.</p> <p>In subsection (E), this standard is too harsh. Further, it may not comply with the civil rights of persons with disabilities. The Department should allow good cause if a medical condition, a disability or circumstances beyond the appellant's reasonable control prevents the appellant from requesting a timely hearing. State law does not require good cause to be limited to factors only involving postal or Department error.</p>	<p>The rule already allows a verbal request, which includes telephone requests.</p> <p>The Department agrees and has deleted "and the issue on appeal."</p> <p>The Department disagrees with this comment. This standard has been approved by the Court of Appeals, and is subject to the requirements of the ADA and the requirements of due process, as are all of the Department's rules. This standard is necessary for consistency with other Department appeals rules, and to ensure administrative finality.</p>
<p>In R6-17-905(B), impossible is too high a standard.</p>	<p>The Department believes that because "unreasonable" is also used in this subsection, this concern is adequately addressed by the rules already. The Department is not imposing a standard of solely impossibility, but allows for unreasonableness as well.</p>
<p>In R6-17-906(A), appellants should be allowed to appear in person when telephonic hearings are not appropriate or the appellant requests it.</p> <p>In subsection (D), the notice of hearing should also include a citation to the law involved so that the appellant may have the opportunity to sufficiently prepare for the hearing.</p>	<p>The Department does not believe that the appellant is entitled, by right, to appear in person. Necessity and administrative efficiency may require that the hearing officer schedule a telephonic hearing.</p> <p>The Department does not have the resources to accommodate this request. Further, in order to accomplish this request, the Department would need to require appellants to identify their issue for appeal in their request for hearing, something that the Department does not require. This allows the uniformed appellant to more fully develop the issue for appeal during the hearing, with the assistance of the hearing officer.</p>
<p>In R6-17-907(B), appellants will not know that it is their duty to ensure that the office of appeals received their request for postponement at least 5 working days before the hearing. Appellants are held to the scheduled hearing date until such time that they are advised that the hearing is postponed.</p> <p>In subsection (C), to comport with due process, there should be a requirement that Notices of Rescheduled Hearings should be sent at least 10 days before the rescheduled hearing to give the appellant sufficient time to arrange their schedule to be at the hearing. Otherwise, the Office of Appeals could send the notice of rescheduled hearing to the appellant any number of days, including the day before, the rescheduled hearing. If mailed, the appellant may not receive actual notice of the hearing as it would not be delivered until the day of, or the day after, the hearing. The appellant could also agree to less than 10 days notice. One day notice of rescheduled hearings has occurred in Tucson on several occasions, and when the appellant does not appear for the hearing, the appeal is dismissed.</p>	<p>The Department informs the appellant of this requirement in the notice of hearing, and will review this notice to ensure that this requirement is clear.</p> <p>The Department agrees, and has amended the rule to read: When the Office of Appeals reschedules a hearing under this Section or R6-17-914, the Office of Appeals shall mail the notice of rescheduled hearing at least 11 days prior to the date of the rescheduled hearing.</p>

Notices of Exempt Rulemaking

Comment	DES Response
In R6-17-909, requiring an affidavit to be filed to request a change in hearing officers is too high a standard. Most appellants are not represented and won't know how to complete an affidavit. Appellants should only be required to request a change of hearing officer by a written statement or by verbal request. If the Department wants uniformity, they should make a form available to appellants. However, the form should not be required if the person does not have one.	A.R.S. § 41-1992(B) requires that the appellant file an affidavit.
In R6-17-910(C)(4), appellants should only be required to include the location of the item if the appellant knows the location.	The Department agrees, and the rule has been amended accordingly.
In R6-17-912(A)(1), who will audiotape the withdrawal? Will equipment be available? Currently, if the appellant wishes to withdraw an appeal, the Department takes the verbal request over the phone and sends the withdrawal form to the appellant for his or her signature. If it is not returned, the hearing process continues through its normal process.	The Department has changed "shall" to "may." If the withdrawal is made to a hearing officer, the withdrawal will be audiotaped. If the withdrawal is made in a local office, the Department does not have the resources to audiotape the withdrawal.
In R6-17-913(D), most GA appellants are not represented and will not be able to brief a case. The matter should be set for hearing so that the appellant can verbally assert his or her position.	The Department has amended subsection (D) to indicate that the Department will set the matter for a hearing.
In R6-17-914(D), limiting a statement to 3 minutes should not be done by regulation, but should be at the hearing officer's discretion. In subsection (E), why doesn't the Office of Appeals provide an automatic waiver of copying charges for this class of applicants/recipients?	The Department has eliminated this requirement. This provision is a uniform rule for all Department appeals cases. The Department believes that the provision allowing GA applicants and recipients to obtain a waiver by submitting an affidavit stating that the party cannot afford to pay is a sufficient protection of the recipient's right to the transcript.
Why don't the rules contain information about the waiting list that the GA program may implement in the future?	The Department has not yet determined how the waiting list process will be handled. Because these rules must be filed by 8/22/03, the Department will address waiting list regulations in a future rulemaking package.

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. Were these rules previously adopted as emergency rules?

No

15. The full text of the rules follows:

TITLE 6. ECONOMIC SECURITY

CHAPTER 17. DEPARTMENT OF ECONOMIC SECURITY
GENERAL ASSISTANCE PROGRAM

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ARTICLE 8. MAINTAINING BENEFITS

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- R6-17-801. Eligibility Review
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ARTICLE 9. APPEALS AND HEARINGS

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- R6-17-912. Withdrawal of an Appeal
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ARTICLE 1. GENERAL ASSISTANCE PROGRAM; PURPOSE AND DEFINITIONS

R6-17-101. Purpose

- A.** The General Assistance (GA) Program is an interim cash benefits program, provided to the following individuals during the period an application has been filed and is pending with the Social Security Administration for federal disability benefits:
 - 1. Disabled persons who agree to reimburse the Department out of any federal disability benefits received; and
 - 2. Caretakers of disabled persons.
- B.** Eligibility determinations for the General Assistance Program are completed by the Family Assistance Administration (FAA).
- C.** Notwithstanding the fulfillment of any eligibility requirement for any component of General Assistance, an individual is not entitled to GA benefits.

R6-17-102. Definitions

The following definitions apply to this Chapter:

- 1. "Acceptable medical source" means licensed physician, including medical or osteopathic doctor; licensed psychologist; licensed psychiatrist; licensed optometrist; and licensed podiatrist, as applicable for the particular medical impairment.
- 2. "Administration" means the Family Assistance Administration of the Department.
- 3. "Adverse action" means any of the following:
 - a. The right to apply for assistance is denied;
 - b. An application for assistance is denied;
 - c. Action to approve or deny an application is not taken within 60 days of the application file date;
 - d. Assistance is terminated or reduced;
 - e. A determination that an overpayment of assistance has been made; or
 - f. A request for a waiver of an overpayment is denied.
- 4. "AIMBIG" or "Arizona Integrated Manual Benefit Information Guide" means the policies and procedures used to determine an assistance unit's eligibility for General Assistance.

Notices of Exempt Rulemaking

5. “Appeals Board” means the Department’s independent, quasi-judicial, administrative appellate body, established under A.R.S. § 23-672, and authorized to review administrative decisions issued by hearing officers as prescribed in A.R.S. § 41-1992(D).
6. “Appellant” means an applicant or recipient who requests a hearing with the Office of Appeals to appeal an adverse action imposed by the Department.
7. “Applicant” means a person who has directly, or through a representative, filed an application for GA with the Department.
8. “Assistance unit” means a group of persons whose needs, income, resources, and other circumstances are considered as a whole for the purpose of determining eligibility and benefit amount.
9. “Available income or resources” means income or resources that are actually available for use by the assistance unit. It includes income or resources in which the applicant or recipient has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and maintenance.
10. “CA” or “Cash Assistance” means temporary assistance for needy families paid to a recipient for the purpose of meeting basic living expenses, as defined in A.R.S. § 46-101.
11. “Collateral contact” means an individual, agency, or organization the Department contacts to confirm information provided by the applicant or recipient.
12. “Countable income” means the amount of income of the assistance unit that the Department considers to determine eligibility and compute a benefit amount under R6-17-601.
13. “Day” means a calendar day unless otherwise specified.
14. “Department” means the Arizona Department of Economic Security.
15. “District Medical Consultant” means a licensed physician whom the Department employs to review medical records for the purpose of determining physical or mental incapacity.
16. “EBT” or “Electronic Benefit Transfer” means the electronic disbursement of benefits to eligible recipients.
17. “Equity value” means the fair market value of a resource minus any legal debt owed on the resource.
18. “FAA” or “Family Assistance Administration” means the administration within the Department’s Division of Benefits and Medical Eligibility responsible for providing financial and food stamp assistance to eligible persons and determining eligibility for medical assistance.
19. “Fair consideration” means an amount that reasonably represents the fair market value of transferred property.
20. “Fair market value” means the value at which property would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy or sell, and both having reasonable knowledge of the relevant facts.
21. “Federal disability benefits” means SSI and SSDI.
22. “GA” means General Assistance as provided in this Chapter.
23. “GA caretaker” means a GA recipient who is receiving GA as a full-time care provider to a disabled person.
24. “Hearing officer” means an individual appointed by the Department Director under A.R.S. § 41-1992(A) to conduct hearings when an appellant challenges an adverse action.
25. “Homebound” means a person who is confined to the home because of physical or mental incapacity.
26. “Homestead property” means:
 - a. A home that is owned and occupied by an applicant or recipient, or
 - b. A home that is co-owned by the applicant or recipient and a separated or divorced spouse of the applicant or recipient, and is occupied by the separated or divorced spouse.
27. “Institution” means a facility such as a hospital or nursing home, but does not include a penal facility.
28. “Income” means earned and unearned income combined.
29. “In-kind income” means the value of goods or services received for work in lieu of the receipt of wages.
30. “Intentional Program Violation (IPV)” means an act committed by an applicant or recipient, for the purpose of establishing or maintaining eligibility for GA or for increasing or preventing a reduction in the amount of assistance, which is intended to mislead, misrepresent, conceal, or withhold facts or propound a falsity.
31. “Liquid asset” means cash or another financial instrument that is readily convertible to cash.
32. “Local office” means an FAA office that is designated as the office in which GA applications and other documents are filed with the Department and in which eligibility and benefit amounts are determined.
33. “Lump sum payment” means a single payment such as retroactive monthly benefits, non-recurring pay adjustments or bonuses, inheritances, lottery winnings, or personal injury and workers’ compensation awards.
34. “Mailing date,” when used in reference to a document sent first class, postage prepaid, through the United States mail, means the date:
 - a. Shown on the postmark;
 - b. Shown on the postage meter mark of the envelope, if there is no postmark; or
 - c. Entered on the document as the date of its completion, if there is no legible postmark or postage meter mark.
35. “Net income” means the assistance unit’s total gross income less applicable disregards, which is used to compute the benefit amount.

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36. "Notice date" means the date that appears as the official date of issuance on a document or official written notice the Department sends or gives to an applicant or recipient.
37. "Notice of adverse action" means a written notice sent to a recipient when the Department decreases or terminates assistance, as described at R6-17-805.
38. "Office of Appeals" means the Department's independent, quasi-judicial, administrative hearing body, which includes hearing officers appointed under A.R.S. § 41-1992(A).
39. "OSI" or "Office of Special Investigations" means the Department office to which FAA refers cases for investigation of certain eligibility information, investigation and preparation of fraud charges, coordination and cooperation with law enforcement agencies, and other similar functions.
40. "Overpayment" means a financial assistance payment received by or for an assistance unit that exceeds the amount to which the unit is lawfully entitled.
41. "Recipient" means a person, including a GA caretaker, who receives GA benefits.
42. "Request for hearing" means a clear written or verbal expression by an applicant or recipient, or such person's representative, indicating a desire to present the case or issue to a higher authority.
43. "Resident" means a person who meets the definition of A.R.S. § 46-292(A)(1).
44. "Resources" means the assistance unit's real and personal property and liquid assets.
45. "Review" means a review of all factors affecting an assistance unit's eligibility and benefit amount.
46. "Social Disability" means any non-medical impairments or deficiencies which in combination with a medical disability further serve to limit employability. Non-medical impairments include the following:
 - a. Advanced age;
 - b. Language barriers;
 - c. Lack of education; and
 - d. Lack of employment history.
47. "Social Security Disability Insurance (SSDI)" means disability benefits paid pursuant to 42 U.S.C. 401, et seq.
48. "Spendthrift restriction" means a legal restriction on the use of a resource that prevents a payee or beneficiary from spending the resource.
49. "Supplemental Security Income (SSI)" means benefits paid pursuant to 42 U.S.C. § 1381, et seq.
50. "Suitable work" means work for which a person is reasonably qualified.
51. "SVES" means the State Verification and Exchange System, which is 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.
52. "Underpayment" means a monthly benefit payment that is less than the amount for which the assistance unit is eligible, or the Department's failure to issue a benefit payment when such payment should have been issued.
53. "Vendor payment" means a payment that a person or organization who is not a member of an assistance unit makes to a third party to cover assistance unit expenses.
54. "Workforce Investment Act" or "WIA" means the program authorized by 29 U.S.C. 2801 et seq. that provides a comprehensive workforce investment system whose purpose is to increase financial productivity and reduce welfare dependency. WIA provides workforce investment activities designed to increase employment, employment retention and earnings, occupational skills, and the quality of the workforce. WIA replaces the former "Job Training Partnership Act" (JTPA) programs.

ARTICLE 2. INDIVIDUALS WHO MAY QUALIFY FOR ASSISTANCE

R6-17-201. Persons Unemployable Due to Disability

To be eligible for General Assistance as an individual who is unemployable due to disability, as described at R6-17-406:

1. The individual must be unable to engage in substantial gainful employment by reason of a medically determined physical or mental impairment. The impairment must have lasted or be expected to last a continuous period of 12 months or longer, or result in death; or
2. The individual must be unable to engage in substantial gainful employment by reason of a medically determined physical or mental impairment in combination with a social disability, as defined in R6-17-102. The inability to engage in substantial gainful employment must have lasted or be expected to last a continuous period of 12 months or longer.

R6-17-202. A Caretaker of an Individual Who Is Unemployable Due to Disability

A. To be eligible for General Assistance as an individual providing full-time care to a disabled person:

1. The disabled person must comply with R6-17-407, and meet the disability criteria described at R6-17-201(A) or (B) and R6-17-406;
2. The caretaker must reside in the same home as the disabled individual;
3. The need for full-time care must be verified by an acceptable medical source; and
4. The caretaker must meet all financial and non-financial eligibility criteria found in Articles 4, 5, and 6.

B. A caretaker is not eligible for more than one GA benefit, regardless of the number of disabled persons in the household.

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R6-17-203. The Assistance Unit

- A.** The following individuals shall be included in the GA assistance unit:
 - 1. The applicant, and
 - 2. The legal spouse of the applicant, when residing together.
- B.** The Department shall pay a cash benefit amount only for the needs of an eligible applicant. When the assistance unit consists of the applicant and the applicant's legal spouse who is also applying for GA, the Department shall determine eligibility and, when eligible, pay one cash benefit amount to the assistance unit based on the needs of both applicants.
- C.** A spouse who is receiving Supplemental Security Income paid from Title XVI of the Social Security Act is excluded from the assistance unit.

ARTICLE 3. REQUESTING BENEFITS

R6-17-301. Client Responsibilities at Initial Application

- A.** A person may apply for GA by submitting an identifiable Department-approved application to an FAA office in person, by mail, or by fax transmittal.
- B.** An identifiable application means an application that contains:
 - 1. The legible name and address of the applicant; and
 - 2. The signature of the applicant, the applicant's representative, or, if the applicant is incompetent or incapacitated, someone legally authorized to act on behalf of the applicant.
- C.** The application file date is the date an identifiable application is received in any FAA office. If the applicant is eligible, benefits will be paid as calculated from this date.

R6-17-302. Agency Responsibilities at Initial Application

- A.** Upon receipt of an identifiable application, the Department shall:
 - 1. Date stamp the application with the application file date;
 - 2. Schedule an initial face-to-face eligibility interview with the applicant at a location that assures a reasonable amount of privacy; and
 - 3. If requested, schedule an initial interview at the residence of an applicant that is homebound. The Department shall mail the homebound applicant written notice of a scheduled home interview at least seven days before the date of the interview.
- B.** The Department shall assist the applicant in completing the application if necessary. A completed application shall contain:
 - 1. The names of all persons living in the applicant's dwelling and their relationship to the applicant;
 - 2. A request to receive GA benefits; and
 - 3. All financial and non-financial eligibility information requested on the application form.

R6-17-303. Client Responsibilities at the Initial Interview

- A.** The applicant shall attend the interview. A person of the applicant's choosing may also attend the interview with the applicant.
- B.** Missed Appointments
 - 1. If the applicant misses a scheduled appointment for an interview, the applicant shall:
 - a. Request to reschedule the interview no later than close of business on the day of the missed appointment; and
 - b. Attend the second scheduled appointment.
 - 2. If the applicant fails to comply with the requirements in (1)(a) or (b), without good cause, the Department shall deny the application and the applicant may reapply to receive benefits. Good cause for failure to comply with the requirements in subsection (B)(1)(a) or (b) is any unanticipated occurrence that, in the discretion of the Department, made it impossible or unreasonable for the applicant to attend the interview or contact the local office.
- C.** An applicant for assistance shall:
 - 1. Give the Department complete and truthful information;
 - 2. Inform the Department of all changes in income, assets, or other circumstances affecting eligibility that have occurred since the date of application for benefits, as prescribed in R6-17-302(A)(1);
 - 3. Complete the Finger Imaging requirements as prescribed in A.R.S § 46-217;
 - 4. Comply with Electronic Benefit Transfer (EBT) requirements; and
 - 5. Comply with any other procedural requirements contained in this Chapter or in state or federal statute.
- D.** An applicant shall provide required verification of financial and non-financial eligibility information or request assistance from the Department in obtaining the information.
 - 1. An applicant shall provide the Department with all requested verification of financial and non-financial eligibility factors, or request the Department's assistance in obtaining the requested verification within 10 calendar days from the date of a written request for such information. An applicant shall provide the Department verification of alien registration status within 20 calendar days from the date of a written request for such verification.

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2. An applicant shall provide the Department with verification of financial and non-financial eligibility factors by submitting to the Department:
 - a. Documents originating from an agency, organization, or individual qualified to have knowledge of the provided information; or, when documented verification is not available to the applicant or when requested by the Department;
 - b. The name, phone number, and address of an agency, organization, or individual qualified to have knowledge of the requested eligibility information and that the Department may use as a collateral contact.
 - c. A signed written statement from the applicant that describes facts specific to an eligibility factor when documented or collateral verification is not available. The Department shall not accept an applicant's signed and written statement as acceptable verification of the following eligibility factors:
 - i. Identity.
 - ii. Social Security number.
 - iii. Citizenship.
 - iv. Alien registration status.
 - v. Relationship of household members.
 - vi. Disability, and
 - vii. Household expenses.

R6-17-304. Agency Responsibilities at the Initial Interview

A. During the interview, a Department representative shall:

1. Discuss how the applicant and the other assistance unit members previously met their needs and why they now need financial assistance;
2. Provide the applicant with written information explaining:
 - a. The terms, conditions, and obligations of the GA program, including the requirements that the applicant must comply with the Arizona Finger Imaging (AFIP) requirements, as required in A.R.S. § 46-217, and obtain and provide a social security number to the Department;
 - b. Any additional required verification information that the applicant must provide for the Department to conclude the eligibility evaluation;
 - c. The Department's practice of exchanging eligibility and income information through the State Verification and Exchange System (SVES);
 - d. The coverage and scope of the GA program, including time-limited assistance provisions as contained in R6-17-408, and reimbursement requirements as contained in R6-17-407;
 - e. Related services that may be available to the applicant;
 - f. The applicant's rights, including the right to appeal adverse action;
 - g. The requirement to report all changes, as specified in R6-17-802, within 10 calendar days from the date the change becomes known; and
 - h. Other benefits for which any person in the assistance unit may be potentially eligible and the requirement that those other benefits must be applied for and accepted, if eligibility exists;
3. Inform the applicant that the Department shall assist the applicant in obtaining required verification at the request of the applicant, when the verification provided by the applicant is insufficient to complete an eligibility determination, or when the required verification is difficult or impossible for the applicant to obtain;
4. Review the penalties for perjury and fraud, as printed on the application;
5. Review any verification information provided with the application or at the initial interview;
6. Review all ongoing reporting requirements, and the potential consequences for failure to make timely reports, including overpayment liability;
7. Offer an applicant who is a United States citizen the opportunity to register to vote, and provide the applicant with a voter registration form if requested; and
8. Witness the signature of the applicant or the applicant's representative.

B. The Department shall obtain independent verification or corroboration of information provided by the applicant when required by law, or when necessary to determine eligibility or benefit level.

C. The Department may verify or corroborate information by any reasonable means including:

1. Contacting third parties such as employers;
2. Asking the applicant to provide documented verification, such as billing statements or pay stubs;
3. Asking the applicant to provide a signed written statement that describes facts specific to an eligibility factor when documented or collateral verification is not available;
4. Conducting a computer data match through SVES; and
5. Referring a case to the Department's Office of Special Investigations (OSI) for investigation when:
 - a. The Department has valid reason to suspect that an act has been committed for the purpose of deception, misrepresentation, or concealment of information relevant to a determination of eligibility or the amount of a benefit payment; or

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- b. FAA suspects the commission of theft or fraud related to GA or any conduct listed in A.R.S. § 46-215.

R6-17-305. Processing the Initial Application

- A.** The Department shall complete the eligibility determination and benefit level computation within 60 calendar days of the application file date, unless:
 - 1. The application is withdrawn. An applicant may withdraw an application at any time before the Department completes an eligibility determination by requesting a withdrawal from the Department either verbally or in writing.
 - a. If an applicant verbally requests to withdraw an application the Department shall:
 - i. Document the names of persons and type of benefits or services from which the applicant wishes to withdraw, and
 - ii. Deny the application and notify the applicant.
 - b. A withdrawal is effective as of the date of application.
 - c. When an application is withdrawn, an applicant may file a new application to request benefits.
 - 2. The applicant dies. If an applicant dies while the application is pending, the Department shall deny the application.
 - 3. The Department is aware of a delay in receiving verification of a required eligibility factor. In this case the Department shall assist the applicant in obtaining the required verification, even if the delay extends beyond 60 days.
- B.** The Department shall deny an application and send the applicant a written notice of denial that shall include an explanation of the assistance unit's appeal rights when the applicant:
 - 1. Fails to complete the application as prescribed in R6-17-302(B) and complete an eligibility interview, as prescribed in R6-17-303;
 - 2. Fails to cooperate with all required Department procedures without good cause. However, the Department shall not take such actions unless the Department has advised the applicant or recipient of these procedural requirements in writing;
 - 3. Fails to meet all of the mandatory financial and non-financial eligibility criteria used to establish eligibility for the GA program; or
 - 4. Fails to meet the verification requirements provided in R6-17-303(D).

R6-17-306. Case Record

- A.** The case record shall contain all data collected or used by the Department in evaluating and determining eligibility and benefit amount.
- B.** The Department shall maintain a case record for every applicant for, or recipient of, assistance.
- C.** Except as otherwise provided in subsections (D) and (E) below, the Department shall retain the case record for a period of three years after the last date on which the applicant received an adverse determination of eligibility or the recipient last received a GA benefit payment.
- D.** The Department shall retain a case record that contains an unpaid overpayment until:
 - 1. The overpayment is paid in full; or
 - 2. The assistance unit is no longer obligated to repay the overpayment.
- E.** The Department shall retain a case record that includes a person determined to have committed an Intentional Program Violation pursuant to Article 8 until the overpayment is paid in full.
- F.** The Department shall retain a case record that includes a disqualification imposed under A.R.S. § 13-3418 or any other applicable criminal that prohibits the receipt of assistance, as defined in A.R.S. § 46-101.

R6-17-307. Confidentiality

- A.** Personally identifiable information.
 - 1. All personally identifiable information concerning an applicant or recipient in the possession of the Department is confidential and not subject to public inspection, except as otherwise specified in A.R.S. § 41-1959 and this Section.
 - 2. Personally identifiable information includes:
 - a. Name, address, and telephone number;
 - b. Social security number and date of birth;
 - c. Unique identifying numbers such as a driver's license number;
 - d. Photographs;
 - e. Information related to social and economic conditions or circumstances;
 - f. Medical data, including diagnosis and past history of disease or disability; and
 - g. Any other information that is reasonably likely to permit another person to readily identify the subject of the information.
- B.** Release of information to applicants and recipients.
 - 1. The Department shall not release confidential information obtained without the applicant's or recipient's knowledge, such as information from the Office of Special Investigations (OSI), to the applicant or recipient. The Department shall only release such information pursuant to a court order, or with the permission of OSI.
 - 2. An applicant or recipient may review the contents of their own case record at any time during the Department's regular business hours, provided that a Department employee is present during the review.

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3. The Department may withhold medical information contained in the case file from an applicant or recipient until the Department contacts the patient's physician and obtains an opinion that the Department can safely release the information.
- C.** Release of information to another person. An applicant or recipient may permit the release of information from the applicant or recipient's eligibility file to another person or representative by executing a release form containing the following information:
 1. The specific information the Department is authorized to release;
 2. The name of the person to whom the Department may release information;
 3. The duration of the release, if limited; and
 4. The signature of the applicant or recipient and the date that the release is signed.
- D.** Release to persons and agencies for official purposes.
 1. An official purpose, as used in this subsection, means a purpose directly related to the administration of a public assistance program and includes:
 - a. Establishing eligibility;
 - b. Determining the amount of an assistance benefit;
 - c. Providing services to applicants and recipients, including child support enforcement services;
 - d. Investigating or prosecuting civil or criminal proceedings related to an assistance program; and
 - e. Evaluating, analyzing, overseeing, and auditing program operations.
 2. The Department may release confidential information to the following persons and agencies as required for official purposes:
 - a. Department employees;
 - b. Employees of the Social Security Administration;
 - c. Public assistance agencies of any other state;
 - d. Persons connected with the administration of child support enforcement activities;
 - e. The Office of the Arizona Attorney General;
 - f. Persons connected with the administration of federal or federally assisted programs that provide assistance, in cash or in-kind, or services directly to individuals on the basis of need;
 - g. Government auditors, when the audits are conducted in connection with the administration of any assistance program by a governmental entity that is authorized by law to conduct such audits;
 - h. AHCCCS, for eligibility purposes; and
 - i. Law enforcement officials for an investigation, prosecution, or civil or criminal proceeding conducted by or on behalf of the Department or a federal public assistance agency in connection with the administration of a public assistance program.
- E.** The Department may also release information concerning a recipient to a federal, state, or local law enforcement officer under A.R.S. § 46-134.

R6-17-308. Manuals

Each FAA office shall make the Arizona Integrated Manual Benefit Information Guide (AIMBIG), as defined in R6-17-102, available for public inspection during regular business hours.

ARTICLE 4. NON-FINANCIAL ELIGIBILITY DETERMINATION

R6-17-401. Age

An applicant for GA must be at least 18 years of age. However, an 18-year old who is potentially eligible for benefits under the Cash Assistance Program, as specified in 6 A.A.C. 12, is not eligible for GA.

R6-17-402. Identity

An applicant for GA shall provide the Department with verification that reasonably establishes the applicant's identity.

1. Verification that reasonably establishes identity includes:
 - a. A driver's license or state issued identification card that contains a photo of the applicant;
 - b. Documents such as the applicant's birth certificate, school identification card, citizenship and immigration documents, identification card from health benefits or other social service programs, wage stubs, work identification card, voter registration card, or other such documents; or
 - c. Collateral verification, as defined at R6-17-303(D)(2)(b), from an individual who shall not benefit from the applicant's receipt of GA.
2. An applicant's written statement is not sufficient verification of identity.

R6-17-403. Citizenship and Legal Alien Status

To be eligible for GA, an applicant must be:

1. A United States citizen, or
2. An alien lawfully admitted for permanent residence in the United States, as verified by the federal Bureau of Citizenship and Immigration Services of the Department of Homeland Security.

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R6-17-404. Social Security Number

The applicant shall apply for or provide the Department with a social security number (SSN). If an applicant lacks an SSN, the Department shall assist the person in applying for an SSN by referring the person to the appropriate local Social Security Administration office.

R6-17-405. Residency

- A.** Only an Arizona resident is eligible for GA.
- B.** A person terminates Arizona residency by leaving Arizona for a period of more than 30 days with the intent to live elsewhere, as provided in A.R.S. § 46-209.
- C.** The Department shall verify Arizona residency as prescribed in R6-17-304.
- D.** A resident of an institution is not eligible for GA in any month in which the institution does not bill the resident for the following:
 - 1. Food.
 - 2. Medication.
 - 3. Shelter.
- E.** American Indians residing on a reservation are not eligible for GA.

R6-17-406. Disability and Employability Determination

- A.** When an applicant is requesting GA as a person who is unemployable due to a disability as described in R6-17-201(1) or (2), the Department shall verify the disability and employability status of the applicant.
- B.** The disability and employability status shall be verified by a medical statement from an acceptable medical source authorized to practice in the state of Arizona.
- C.** An applicant shall be considered disabled when any of the following is verified by a medical statement from an acceptable medical source licensed to practice in the state of Arizona.
 - 1. The applicant has a physical or mental impairment that is expected to result in death.
 - 2. The applicant has a physical or mental impairment that has lasted or can be expected to last for a continuous period of not less than 12 months.
 - 3. The applicant has any of the following medical conditions:
 - a. Acute leukemia;
 - b. Alzheimer's disease;
 - c. Amputation of both legs, both feet, both arms, or both hands;
 - d. Rheumatoid arthritis with obvious crippling deformities;
 - e. Legal blindness;
 - f. Brain tumor(s);
 - g. Lung cancer;
 - h. Cirrhosis of the liver with ascites for at least five months or esophageal varices with massive hemorrhage;
 - i. Total deafness;
 - j. Dementia;
 - k. Diabetes with amputation or blindness;
 - l. Heart, kidney, or liver transplants;
 - m. HIV Positive with secondary infection;
 - n. Mental retardation with additional physical or mental problems;
 - o. Neurological disease;
 - p. Parkinson's disease with observable limitations of function;
 - q. Chronic obstructive pulmonary disease, on 24-hour oxygen;
 - r. End stage renal disease or on dialysis;
 - s. Schizophrenia, other than the first breakdown, or other chronic mental impairment such as, but not limited to, long-term depression or severe mental illness;
 - t. Spinal chord lesions with paralysis;
 - u. Stroke with paralysis on one side (arm or leg) or communication problems; or
 - v. Terminal illness.
- D.** When an applicant is requesting GA as a person who is providing full-time care to a disabled person, as described in R6-17-202, the disabled person must fulfill the disability verification requirements listed in subsection (B) of this rule.
- E.** The Department shall assist an applicant who does not have access to an acceptable medical source in obtaining the verification items listed in subsection (C) of this rule, by making an appointment with a licensed physician who shall examine, diagnose, and provide the Department a written evaluation of the disability and employability status of the applicant.
- F.** In situations when the physician's statement is incomplete or insufficient to determine disability and employability status, the local office shall forward the case record to the District Medical Consultant (DMC), as defined in R6-17-102, who shall make a determination.

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1. The DMC shall review all medical data and may refer the applicant to an acceptable medical source for another examination, diagnosis, and evaluation prior to rendering a disability determination.
2. As a condition of eligibility, the applicant shall comply with the DMC requirement to be examined, diagnosed, and evaluated by an acceptable medical source designated by the DMC.
3. The local office shall abide by the DMC determination in determining disability and employability status of the applicant.

G. An applicant may appeal an adverse determination of disability and employability status as provided in Article 9.

R6-17-407. Application for Federal Disability Benefits; Authorization of Reimbursement; and Assignment of SSDI Benefits

A. The following persons shall apply for federal disability benefits with the Social Security Administration (SSA), as defined in R6-17-102, and provide verification that SSA has received the application and that an interview with SSA has been completed:

1. An applicant requesting GA as a person who is unemployable due to a disability as described in R6-17-201(1) or (2), and
2. The disabled person for whom an applicant is providing full-time care as described in R6-17-202.

B. An applicant requesting GA as a person who is unemployable due to a disability shall sign:

1. A Department approved Interim Assistance Reimbursement Authorization form that authorizes:
 - a. The Social Security Administration to send the initial SSI payment of federal disability benefits to the Department, and
 - b. The Department to use the payment to reimburse the Department for the amount of all GA payments paid to the applicant.
2. An assignment of SSDI benefits that requires the recipient to reimburse the Department for the amount of all GA payments paid to the applicant.

R6-17-408. Time-limited Assistance

A. The Department shall authorize GA benefits to an eligible recipient, for not more than 12 months within a 36 consecutive month period, except for a recipient who is a GA caretaker.

1. The 36 consecutive month period shall begin the first eligible month on or after February 1, 2001 for which the Department issues a GA benefit, and shall terminate on the last day of the 35th month following such month.
2. The Department shall count each payment month within the 36-month period, except for months paid in accordance with subsection (C), until a limit of 12 months is reached. The 12 months need not be consecutive. When 12 months of payments have been issued, the Department shall terminate GA eligibility, unless the requirements at R6-17-806 are met.

B. A GA caretaker becomes ineligible for assistance when the disabled person for whom they are providing caretaker services is denied federal disability benefits by the Social Security Administration.

C. When a GA recipient becomes ineligible due to denial of the disabled individual's application for federal disability benefits with the Social Security Administration, the recipient may receive up to six months of cash benefits if the requirements of R6-17-806 are met.

ARTICLE 5. TREATMENT OF RESOURCES AND INCOME

R6-17-501. Resource Limitations

A. An applicant for GA is not eligible for benefits if the applicant has resources in excess of the following, after the exclusions in subsection (B) are applied:

1. \$1000 for an assistance unit consisting of only the applicant.
2. \$1400 for an assistance unit consisting of the applicant and the applicant's spouse.

B. The Department shall exclude the equity value of the resources listed below:

1. The homestead of the assistance unit, as defined in R6-17-102, not to exceed a current equity of \$50,000;
2. Household furnishings used by the assistance unit in their residence, and personal effects essential to day-to-day living;
3. \$1500 of the current equity value of one vehicle in the assistance unit. When two or more vehicles are owned, the Department shall apply the exclusion to the vehicle with the highest equity value. Jointly owned vehicles, with ownership records containing the word "or" between the owners' names, are available in full to each owner unless it can be proven by the assistance unit member that the vehicle is not available to them or not in their possession. When more than one owner is a member of an assistance unit, the equity value of the resource is counted only once.
4. Funds established in connection with settling liability claims concerning Agent Orange death or disability;
5. Any other resource specifically excluded by law.

R6-17-502. Resource Verification

The Department shall verify all resources, as defined in R6-17-102, held or transferred by an assistance unit within one year prior to the application.

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R6-17-503. Availability and Ownership of Resources

- A.** The Department shall consider a resource as countable to the assistance unit only when the resource is legally and physically available, or in the possession of the assistance unit member.
- B.** The Department shall consider the availability of property to the assistance unit based on the type of ownership.
1. The sole and separate property of one spouse is available to the other spouse only when the spouse/owner makes the property available. A resource shall be considered sole and separate property only when obtained in one of the following manners:
 - a. Before the present marriage, or
 - b. At any time by gift or inheritance.
 2. Jointly owned resources, with ownership records containing the words “and” or “and/or” between the owners’ names, are deemed available when all owners can be located and consent to disposal of the resource, except that such consent is not required when all owners are members of the assistance unit.
- C.** The Department considers the following resources unavailable to the assistance unit:
1. Any resource owned solely by a spouse who is receiving Supplemental Security Income (SSI) paid by Title XVI of the Social Security Act.
 2. Resources being disputed in divorce proceedings or in probate matters.
 3. Real property situated on a Native American reservation.

R6-17-504. Limitations on Resource Transfers

The following provisions apply to an applicant or recipient who transfers a resource with the intent to qualify or remain qualified for GA:

1. An applicant or recipient shall not transfer a resource for GA within one year prior to application or while receiving assistance, unless fair consideration, as defined in R6-17-102, was received.
2. When an applicant or recipient disposes of homestead property, the Department shall count all proceeds of the sale not reinvested in homestead property as a resource, when the applicant or recipient:
 - a. Invests the proceeds in a resource other than homestead property,
 - b. Advises the Department that such proceeds will not be reinvested in other homestead property, or
 - c. Fails to purchase new homestead property within 90 days of the date of sale.
3. Eligibility shall not be affected when a home is transferred because the person cannot continue residing in the home for health reasons, as determined by a licensed physician.
4. Except as otherwise provided in this Section, when an applicant or recipient does not receive fair consideration for a transferred resource, the assistance unit shall be ineligible to receive GA.
 - a. The period of ineligibility begins in the month the transaction occurred.
 - b. The Department determines the duration of ineligibility by subtracting the consideration actually received, from the equity value of the transferred resource, and dividing that sum by the monthly need standard for the assistance unit. The resulting number shall be the number of months the unit is ineligible.
 - c. Eligibility shall not be affected when the equity value of a transferred resource, plus the value of the unit’s other available resources, does not exceed the resource limitation as specified in R6-17-501.

R6-17-505. Nonrecurring Lump Sum Payments

- A.** The Department shall count nonrecurring lump sum payments, as defined in R6-17-102, as a resource beginning in the month received.
- B.** Any part of a lump sum payment that will recur in future months shall be counted as income in the month received.

R6-17-506. Treatment of Income: Overview

- A.** “Income” includes the following, when actually received by the assistance unit:
1. Gross earned wages from public or private employment, before any deductions;
 2. In-kind income, as defined in R6-17-102;
 3. For self-employed persons, the sum of gross business receipts minus business expenses;
 4. Unearned monetary gains such as GA benefits, minus any deductions to repay prior overpayments or attorney fees, except as provided in subsection (A)(5);
 5. A prorated share of any cash assistance benefit received by the applicant’s spouse.
- B.** The Department considers all gross income available to the assistance unit in determining eligibility, except for those types of income excluded under R6-17-507.

R6-17-507. Income Exclusions

The types of income listed in this Section are not counted when determining the income available to an assistance unit.

1. One-half of the countable income of the applicant’s spouse;
2. One-half of the prorated share of any Cash Assistance benefits received by the applicant’s spouse;
3. Loans;
4. Educational grants or scholarships;

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5. Income tax refunds;
6. The value of food stamp benefits and benefits from the Special Supplemental Food Program for Women, Infants, and Children (WIC);
7. Energy assistance payments or allowances provided under any federal, state, or local law, including Negative Rent Utility Payments issued by the Department of Housing and Urban Development for the purpose of energy assistance.
8. Vendor payments, as defined in R6-17-102;
9. Vocational rehabilitation program payments made as reimbursements for training-related expenses, subsistence and maintenance allowances, and incentive payments that are not intended as wages;
10. Agent Orange payments;
11. Burial benefits that are dispersed solely for burial expenses;
12. Reimbursements for work-related expenses that do not exceed the actual expense amount;
13. The earned or unearned income of an SSI recipient;
14. Insurance payments issued to repay a specific bill, debt, or estimate that cannot be used to meet basic daily needs such as housing, food, or other personal expenses;
15. Attorney fees that are included in the gross payment of industrial compensation paid under the workers' compensation law or in legal settlements;
16. In-kind income, as defined in R6-17-102;
17. Earned income received from employment through the Workforce Investment Act (WIA), including earnings received from on-the-job-training; and
18. Any other income specifically excluded by applicable state or federal law.

ARTICLE 6. DETERMINING INCOME ELIGIBILITY AND A CASH BENEFIT AMOUNT

R6-17-601. Calculation of Countable Income and Benefit Amount

- A.** To determine the countable income of an assistance unit, the Department shall:
 1. Calculate a monthly gross income amount using the methods listed in R6-17-602;
 2. Calculate a monthly net income by subtracting any applicable earned income deduction in R6-17-605 from the gross income.
- B.** The Department shall determine the cash benefit amount by comparing the countable income to the GA Payment Standard for the number of eligible GA recipients in the assistance unit, as shown in R6-17-606(2)(c), to determine the amount of the cash benefit as provided in R6-17-606(3).

R6-17-602. Determining Monthly Income

- A.** The Department shall calculate the monthly income of an assistance unit by converting income received other than monthly into a monthly amount, using the methods in R6-17-603.
- B.** The Department shall include in its calculation all gross income from every source available to the assistance unit, as provided in R6-17-506, unless specifically excluded in R6-17-507 or by federal or state statutes.
- C.** The Department shall include in its calculation income that the assistance unit has received and reasonably expects to receive in a benefit month and is based on the Department's reasonable expectation and knowledge of the assistance unit's current, past, and anticipated future circumstances.

R6-17-603. Methods to Determine Monthly Income

- A.** The Department shall convert income received in a regular amount on an ongoing basis into a monthly amount as follows:
 1. Multiply weekly amounts by 4.3;
 2. Multiply bi-weekly amounts by 2.15;
 3. Multiply semi-monthly amounts by 2;
 4. Divide quarterly amounts by 4;
 5. Divide semi-annual amounts by 6; and
 6. Divide annual amounts by 12.
- B.** Averaging income.
 1. The Department shall average income for an assistance unit that receives income:
 - a. Irregularly; or
 - b. Regularly, but from sources or in amounts that vary.
 2. When using this method, the Department shall add together income from a representative number of weeks or months and then divide the resulting sum by the same number of weeks or months.
- C.** Prorating income.
 1. Except as provided in subsection (C)(2), the Department shall prorate income when an assistance unit receives income from a fixed-term employment contract in the following manner:
 - a. Income is prorated over the number of months the contract is intended to cover unless the contract specifies piece-meal or hourly income.

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- b. Applicable earned income disregards apply as if the prorated amounts were received in each month of the contract.
- 2. Income is counted in the month received under R6-17-602 and R6-17-603(A), when the contract specifies that income will be paid on a piece-meal or an hourly basis.

D. Actual income. The Department shall use the actual income of an assistance unit that:

- 1. Receives or reasonably expects to receive less than a full month's income from a new source.
- 2. Receives or reasonably expects to receive less than a full month's income from a terminated source of income, or
- 3. Is paid daily.

R6-17-604. Income Verification

The Department shall verify all income as provided in R6-17-303(D) before determining eligibility and benefit amount.

R6-17-605. Earned Income Deduction

For the purpose of determining the countable earned income to be used in the GA Payment Standard Test, as provided in R6-17-606(2), the Department shall deduct a \$24 work expense deduction from the earned income of each employed person in the assistance unit.

R6-17-606. Determining Income Eligibility and Cash Benefit Amount

To determine income eligibility for a cash benefit, the Department shall:

- 1. Establish whether an A-1 or A-2 Standard shelter cost factor will be used to complete the financial determination.
 - a. The A-1 Standard will be used when:
 - i. 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, and property taxes;
 - ii. The assistance unit members reside in subsidized public housing;
 - iii. A member of the assistance unit works in exchange for rent.
 - b. The A-2 Standard will be used:
 - i. For all circumstances not covered under subsection (1), or
 - ii. When shelter costs are paid for three consecutive months or longer by an organization or a person who is not a member of the assistance unit.
- 2. Conduct a GA Payment Standard Test.
 - a. Using the size of the assistance unit and the applicable A-1 or A-2 Standard, the Department shall compare the countable monthly income to the applicable Maximum GA cash benefit amount as shown on the GA Payment Standard chart in subsection (2).
 - b. If the countable income is at least one dollar less than the GA Maximum cash benefit amount, the household is eligible for GA benefits. If the countable income is equal to or greater than the GA Maximum cash benefit amount the assistance unit is ineligible for GA benefits.
 - c. The GA Payment Standard Chart.

<u>Number of Individuals</u>	<u>Maximum Monthly GA Cash Benefit for A-1 Standard (Based on 0 Countable Income)</u>	<u>Maximum Monthly GA Cash Benefit for A-2 Standard (Based on 0 Countable Income)</u>
1	\$173	\$108
2	\$233	\$145

- 3. Determine the Amount of the Cash Benefit Payment
 - a. The Department shall deduct the countable income from the maximum cash benefit amount, as shown in the chart in subsection (2), and round the difference down to the next whole dollar. The Department shall pay that amount to the assistance unit.
 - b. The initial month's benefits will be prorated by the number of days remaining in the month from the application filing date.

ARTICLE 7. BENEFIT PAYMENTS

R6-17-701. Benefit Payments

- A.** The Department shall pay benefits to an assistance unit for each month in which it is determined eligible.
- B.** The Department shall make benefits available no later than the 60th day following the date of application for the initial month, and on the first day of each month for which the applicable is eligible thereafter.

Notices of Exempt Rulemaking

R6-17-702. Payment Method

The Department shall provide benefit payments by making direct deposits into:

1. An Electronic Benefit Transfer (EBT) account established for the assistance unit by the Department, or
2. A financial institution account established by the recipient.

R6-17-703. EBT Card Issuance

A. The Department shall authorize access to an EBT account to:

1. The recipient, or
2. A representative payee, as provided in R6-17-704.

B. The Department shall provide to each person who has access to an EBT account:

1. Training on EBT rights and responsibilities, prior to issuing such individual an EBT account access card;
2. Assistance with the selection of a Personal Identification Number (PIN);
3. Orientation on the use of the Point of Sale (POS) device, the PIN pad, and the printed receipt;
4. The EBT provider's Customer Service Hotline phone number to report EBT account problems; and
5. Information on the availability of GA Direct Deposit into an open banking account and the process for establishing Direct Deposit.

R6-17-704. Representative

Each assistance unit may designate in writing no more than two representatives who shall have full access to the GA benefit available in the EBT account. Each representative shall:

1. Provide the Department with verification of their identity, and
2. Appear in person for EBT Training, EBT account access card issuance, and PIN selection.

R6-17-705. Change in Arizona Residency

When an assistance unit moves to another state, it is entitled to any benefits remaining in its EBT account.

1. The assistance unit may obtain benefits by accessing the assistance unit's account with the EBT card before leaving Arizona, or in the assistance unit's new state of residence if the EBT card is accepted.
2. If the assistance unit cannot obtain benefits using the EBT card, the Department shall issue a check to the payee of the assistance unit for the balance remaining in the EBT account.

R6-17-706. Replacing Lost, Stolen, or Damaged Cards

The assistance unit shall report a lost, stolen, or damaged EBT account access card as soon as possible, either by phone to the EBT 24-hour Customer Service Department or to the Department during normal business hours.

1. Any funds removed from an EBT account prior to a card being reported as lost or stolen will not be replaced.
2. If the client reports a lost, stolen, or damaged EBT account access card by phone to the EBT 24-hour Customer Service Department, the EBT 24-hour Customer Service Department shall de-activate the EBT account access card and direct the client to contact the local FAA office for issuance of a new card.
3. The Department shall issue a replacement card when:
 - a. The EBT account access card has been de-activated by the EBT system provider or by the Department, and
 - b. The client has appeared in person to request a Replacement card and has provided proof of identity to the Department, as described in R6-17-402.

R6-17-707. Inactive Accounts; Unused Benefits

The assistance unit shall retain the right to access the EBT account for one year from the original date of benefit availability, regardless of the status of the GA case.

1. When an EBT account has not been accessed for a period of 60 days, the Department shall notify the assistance unit in writing. The notice shall state that immediate access to the EBT account will terminate in 30 days unless the Department is contacted or the EBT account is accessed.
2. The assistance unit shall lose immediate access to any benefits in an EBT account that has been inactive for a period of 90 days. To regain access to these benefits, the assistance unit must contact the Department and request to be reinstated to the EBT account.
3. When benefit payments in an EBT account have not been accessed for 365 days after the original date of availability, the Department shall recoup the benefits and the assistance unit shall lose all rights to regain those benefits.
4. Upon the death of a GA recipient, the Department shall recoup from the EBT account any GA benefits paid to the recipient after the month of the recipient's death.

R6-17-708. Supplemental Payments

A. The Department shall correct underpayments by issuing the assistance unit a supplemental payment regardless of whether the underpaid individual is eligible on the date the supplemental payment is issued.

B. The Department shall not count such supplemental payments as a resource or as income.

Notices of Exempt Rulemaking

R6-17-709. Overpayments: Date of Discovery; Collection

An overpayment exists when the financial assistance payment received by, or for, an assistance unit exceeds the amount to which the unit was lawfully entitled.

1. The Department may pursue collection of all overpayments, under A.R.S. § 46-213.
2. The Department shall write an overpayment report within 90 days of the date of discovery. The date of discovery is the date the Department determines that a potential overpayment exists.
3. If the FAA office suspects that the overpayment was caused by fraudulent activity, it shall refer the overpayment report to the Department's Office of Special Investigations for potential prosecution.

R6-17-710. Methods of Collection and Recoupment

A. When an overpaid assistance unit is currently receiving benefits, the Department shall seek recovery using one or more of the following repayment methods:

1. Offset against any underpayment due the unit in the current month;
2. Cash payments;
3. Reduction in current benefits, in an amount not to exceed 10% of the unit's monthly payment, unless the unit desires a larger reduction;
4. A combination of the above methods.

B. If the assistance unit is not receiving benefits, the Department shall pursue recovery by appropriate action under state law.

R6-17-711. Overpayment Calculation Date

When determining an overpayment amount, an assistance unit's overpayment period begins in one of the following:

1. The benefit month for which an initial GA payment is issued, when the assistance unit was ineligible for the amount of assistance paid.
2. The first day of the second month following the month in which the change that resulted in an overpayment of GA cash benefits occurred, or
3. For an overpayment that resulted from GA benefits being paid for more than 12 months in any 36 consecutive month period, the month the 13th payment was issued, beginning no earlier than August 1, 1994.

ARTICLE 8. MAINTAINING BENEFITS

R6-17-801. Eligibility Review

A. The Department shall complete a review of all eligibility factors for each assistance unit at least once every six months, beginning with the fifth month following the first month of GA eligibility.

B. The Department shall mail the recipient a notice 30 days prior to the Department's review date, advising the recipient of the need for a review. In response to such a notice, the recipient shall file an application and complete a review interview by the date specified on the notice.

C. The Department shall schedule and conduct a review interview in the same manner as an initial interview, as described at R6-17-304.

D. The Department shall verify the assistance unit's resources and income and any eligibility factors that have changed or are subject to change. The Department may verify other factors if there is no current verification in the case file.

R6-17-802. Requirement to Report Changes

A. The assistance unit shall report, verbally or in writing, all changes that may affect eligibility or benefit amount within 10 days from the date the change becomes known. This includes changes to any of the following:

1. Residential address;
2. Shelter expenses to establish the applicable A-1 or A-2 shelter cost factor used to complete the financial eligibility determination, as described in R6-17-606(1);
3. Sources and amounts of income, financial assistance, or any assistance that provides help to the assistance unit in meeting their needs;
4. Disability and employability status of either the GA recipient or the disabled individual for whom a GA caretaker recipient is providing full-time care;
5. Approval or denial of federal disability benefits by the Social Security Administration;
6. Individuals residing in the home; and
7. Types, sources, and amounts of resources.

B. The assistance unit shall provide any verification of changes requested in writing by the Department on or before the verification due date specified on the Department's request for verification, using the verification methods prescribed in R6-17-303(D).

R6-17-803. Agency Responsibilities for Processing Changes

A. The Department shall redetermine eligibility for GA benefits and, if applicable, recalculate a GA benefit amount when a change is reported directly by the assistance unit, by a third party, or discovered through an automated system report.

Notices of Exempt Rulemaking

- B.** When a change results in either a decrease in the cash benefit or renders the assistance unit ineligible for GA, the Department shall effect the change within ten days from the date the change was reported, when possible, using one of the following methods:
 - 1. Reduce the benefit or terminate eligibility for the first possible month allowing for notice of adverse action requirements prescribed in R6-17-805, without further verification, if there is sufficient and reliable information to effect the change, or
 - 2. Attempt to obtain verification by the tenth day from the date the change was reported when there is not sufficient information to effect the change without additional verification. The Department shall:
 - a. Send the assistance unit a written request for verification with a due date that is the tenth day from the date the verification is requested, and
 - b. Contact third parties to obtain the needed verification, when possible.
- C.** If the assistance unit fails to provide the requested verification by the due date, and does not request assistance from the Department to obtain the verification, the Department shall terminate GA for the first possible month allowing for notice of adverse action requirements prescribed in R6-17-805.
- D.** When a reported change results in an increase in the cash benefit, the Department shall effect the increase only after the change has been verified. The Department shall send the assistance unit a written request for verification with a due date that is 10 days from the date of the written notice.
 - 1. When the assistance unit provides the requested verification on or before the due date, the Department shall increase the cash benefit for the first regular payment issued after the date the change is reported.
 - 2. When the assistance unit provides the requested verification after the due date, the Department shall increase the cash benefit for the first regular payment issued after the date the verification is received.
 - 3. When the assistance unit does not provide the requested verification, the Department shall not increase the cash benefit but shall continue issuing the current cash benefit amount.

R6-17-804. Reinstatement of Terminated Benefits

- A.** The Department shall reinstate terminated benefit payments within 10 calendar days when:
 - 1. The Department terminated benefit payments in error;
 - 2. The Department receives a court order or administrative hearing decision mandating reinstatement; or
 - 3. The recipient timely files a request for fair hearing and requests continued benefits as provided in R6-17-902. The Department shall not provide continued benefits if the request is for continuance of benefits past the:
 - a. Twelve-month limit set forth at R6-17-408, or
 - b. Six-month limit set forth at R6-17-408.
- B.** When a six-month review was not completed due to the termination of benefits, the Department shall conduct the review at the earliest opportunity following reinstatement.

R6-17-805. Notices of Adverse Action

- A.** A notice of adverse action shall contain:
 - 1. The adverse action taken;
 - 2. The reason for the adverse action;
 - 3. The effective date of the adverse action;
 - 4. The name and phone number of the Administration office to contact for additional information;
 - 5. The phone number for free legal assistance; and
 - 6. The recipient's appeal rights.
- B.** Timely Notice of Adverse Action.
 - 1. When the Department intends to reduce or terminate benefits, the Department shall provide the assistance unit with timely notice of adverse action, except when the reduction or termination is for one of the reasons in subsection (C).
 - 2. The Department shall mail the notice of adverse action first class, postage prepaid, to the last known residential address for the assistance unit, or other designated address for the unit, so as to be reasonably expected to arrive at least 10 days prior to the first day of the effective month.
- C.** The Department may dispense with timely notice, but shall mail the notice of adverse action so as to be reasonably expected to arrive no later than the first day of the effective month when:
 - 1. A recipient makes a written or verbal request for termination;
 - 2. A recipient is ineligible because they have been admitted to a facility where the recipient's needs are being met. This includes:
 - a. Incarceration,
 - b. Long-term hospitalization and the recipient is not expected to return to the home, and
 - c. Institutionalization in a skilled nursing care or intermediate care facility;
 - 3. The recipient's address is unknown;
 - 4. The Department has verified that the recipient has been accepted for assistance in another state;
 - 5. The recipient has been convicted in a court of law of committing an Intentional Program Violation (IPV).

Notices of Exempt Rulemaking

R6-17-806. Extension of the 12-month Time Limit

- A.** A GA recipient that has received 12 months of cash benefits and has been denied federal disability benefits may receive a maximum of six additional months of benefits when the recipient:
1. Provides the Department with proof that an appeal of the denial has been filed with the Social Security Administration, and
 2. All other financial and non-financial GA eligibility factors are met.
- B.** Eligibility during the six additional month period ends at the earliest of the following:
1. Federal disability benefits are received.
 2. The appeal of the denial of federal disability benefits is denied by the Social Security Administration, or
 3. Six months of cash benefits are paid by the Department.

R6-17-807. Interim Assistance Reimbursement

- A.** Within 10 days of receiving the GA recipient's initial SSI payment from the Social Security Administration, as contained in R6-17-407(B), the Department shall:
1. Compute the amount of GA benefits that were paid to the recipient for each month the recipient was eligible for both GA and SSI.
 2. Retain the resulting amount from the initial SSI payment as reimbursement to the Department.
 3. Distribute the remaining amount in one payment to the GA recipient. The Department shall notify the recipient of the recipient's right to a fair hearing to dispute the Department's allocation of the initial SSI payment.
- B.** Within 10 days of being notified of the recipient's initial SSDI payment from SSA, the Department shall send written notice to the recipient requesting reimbursement of GA assistance, pursuant to the assignment signed by the recipient. The notice shall include:
1. The amount of assistance the recipient is obligated to reimburse to the Department;
 2. The payment due date;
 3. The payment methods accepted by the Department;
 4. The name and phone number of a Department representative to contact for additional information;
 5. The phone number for free legal assistance; and
 6. The recipient's appeal rights.
- C.** The Department shall pay the claim of any attorney, or advocate under the supervision of the attorney, for representing a GA recipient in an appeal of any claim for federal disability benefits before an administrative law judge or for a subsequent adjudication or appeal that is decided in favor of the recipient, as required in A.R.S. § 46-238.

ARTICLE 9. APPEALS AND HEARINGS

R6-17-901. Entitlement to a Hearing; Appealable Action

- A.** An applicant or recipient who appeals an adverse action may obtain an administrative hearing to challenge the action as provided in this Article.
- B.** An adverse action resulting from a uniform change in federal or state law is not appealable, unless the Department has misapplied the law to the person seeking the hearing.

R6-17-902. Computation of Time

- A.** In computing any time period.
1. The term "day" means a calendar day;
 2. The term "work day" means Monday through Friday, excluding Arizona state holidays;
 3. The date of the act, event, notice, or default from which a designated time period begins to run is not counted as part of the time period; and
 4. The last day of the designated time period is counted, unless it is a Saturday, Sunday, or Arizona state holiday.
- B.** A document mailed by the Department is deemed given to the addressee on the date mailed to the addressee's last known address. The mailing date is presumed to be the date shown on the document, unless the facts show otherwise.

R6-17-903. Request for Hearing; Form; Time Limits; Presumptions

- A.** A person who wishes to appeal an adverse action shall make a verbal or written request for hearing with the Administration within 30 days of the date on the notice or letter advising the person of the adverse action. The Administration shall provide a form for this purpose, and, upon request, shall help an appellant fill out the form. If the person makes a verbal request for hearing, the Department shall reduce the appeal and the stated reasons for the appeal to writing, record the date of the verbal request, and forward the request to the Office of Appeals.
- B.** An appellant shall include the following information in the request for hearing:
1. Name, address, and telephone number of the person subject to the adverse action;
 2. A description of the adverse action which is the subject of the appeal;
 3. The date of the notice of adverse action; and
 4. A statement explaining why the adverse action is unauthorized, unlawful, or an abuse of discretion.

Notices of Exempt Rulemaking

- C. The Department shall not deny an appeal solely because the request does not include all the information listed in subsection (B), so long as the request contains sufficient information for the Department to determine the identity of the appellant.
- D. A request for hearing is deemed filed:
 - 1. On the mailing date, as shown by the postmark, if sent 1st-class mail, postage prepaid, through the United States Postal Service to the Department; or
 - 2. On the date actually received by the Department, if not mailed as provided in subsection (D)(1).
- E. The Department may determine that a document was timely filed if the sender of the document can demonstrate that the delay in submission was due to any of the following reasons:
 - 1. Department error or misinformation.
 - 2. Delay or other action by the United States Postal Service, or
 - 3. Delay caused by the appellant changing mailing addresses at a time when the appellant had no duty to notify the Administration of the change.
- F. When the Office of Appeals receives a request for hearing that was not timely filed, the Office of Appeals shall schedule a hearing to determine whether the delay in submission is excused as provided in subsection (E).
- G. An appellant whose appeal is denied as untimely may petition for review as provided in R6-17-918.

R6-17-904. Administration: Transmittal of Appeal

- A. The Administration shall notify the Office of Appeals of a request for hearing within two work days of receipt of the request.
- B. No less than 10 work days before the scheduled hearing date, unless otherwise ordered, the Administration shall send the Office of Appeals and the appellant a prehearing summary. The prehearing summary shall include, at a minimum:
 - 1. The appellant's name,
 - 2. The appellant's social security number,
 - 3. The local office that issued the adverse action under appeal,
 - 4. A brief summary of the facts leading to the adverse action, and
 - 5. The legal or Administration policy basis for the adverse action.

R6-17-905. Stay of Adverse Action Pending Appeal

- A. The Department shall stay the implementation of the adverse action until the hearing officer renders a decision on the appeal, if the appellant makes a request within 10 days from the date the Department mails the notice, except in the following circumstances:
 - 1. The appellant expressly waives the delay of action;
 - 2. The adverse action is a result of a uniform change in federal or state law;
 - 3. The appellant is requesting continued benefits when the time period for which the Department has approved benefits has expired;
 - 4. If the Department has denied the appellant's initial or renewal application;
 - 5. The appellant does not request that the Department stay the implementation of a separate pending or subsequent adverse action;
 - 6. The appeal challenges an action that is not appealable according to R6-17-902(B);
 - 7. The appellant withdraws the request for hearing; or
 - 8. The appellant fails to appear for the hearing.
- B. The Department shall extend the 10-day time period in subsection (A) if the appellant establishes good cause. Good cause includes any unanticipated occurrence that, in the discretion of the Department, made it impossible or unreasonable for the appellant to make the request as specified in subsection (A).

R6-17-906. Hearings: Location; Notice; Time

- A. The Office of Appeals shall schedule the hearing. The Office of Appeals may schedule a telephonic hearing or permit a witness, upon request, to appear telephonically.
- B. Unless the parties stipulate to another hearing date, the Office of Appeals shall schedule the hearing no earlier than 20 days from the date the Department receives the appellant's request for hearing.
- C. The Office of Appeals shall mail a notice of hearing to all interested parties at least 20 days before the scheduled hearing date.
- D. The notice of hearing shall be in writing and shall include the following information:
 - 1. The date, time, and place of the hearing;
 - 2. The name of the hearing officer;
 - 3. A general statement of the issues involved in the case;
 - 4. A statement listing the parties' rights, as specified in R6-17-911; and
 - 5. A general statement of the hearing procedures.

Notices of Exempt Rulemaking

R6-17-907. Rescheduling the Hearing

- A.** A party may ask for postponement of a hearing by calling or writing the Office of Appeals and providing good cause as to why the hearing should be postponed. Good cause exists where circumstances beyond the appellant's reasonable control make it difficult or burdensome for the appellant to attend the hearing on the scheduled date.
- B.** Except in emergency circumstances, the appellant shall ensure that the Office of Appeals receives the request for postponement at least five work days before the scheduled hearing date. The Office of Appeals may deny an untimely request. Emergency circumstances mean circumstances:
 - 1. Beyond the reasonable control of the party;
 - 2. That did not arise until after the five-day period; and
 - 3. That could not reasonably have been anticipated.
- C.** When the Office of Appeals reschedules a hearing under this Section or R6-17-914, the Office of Appeals shall mail the notice of rescheduled hearing at least 11 days prior to the date of the rescheduled hearing.

R6-17-908. Hearing Officer: Duties and Qualifications

- A.** An impartial hearing officer in the Office of Appeals shall conduct all hearings.
- B.** The hearing officer shall:
 - 1. Administer oaths and affirmations;
 - 2. Regulate and conduct hearings in an orderly and dignified manner that avoids unnecessary repetition and affords due process to all participants;
 - 3. Ensure that all relevant issues are considered;
 - 4. Exclude evidence that is not competent, relevant, or material, or that is unduly repetitious from the record;
 - 5. Request, receive, and incorporate into the record, relevant evidence;
 - 6. Upon compliance with the requirements of R6-17-911, subpoena witnesses or documents needed for the hearing;
 - 7. Open, conduct, and close the hearing;
 - 8. Rule on the admissibility of evidence offered at the hearing;
 - 9. Direct the order of proof at the hearing;
 - 10. Upon the request of a party, or on the hearing officer's own motion, and for good cause shown, take action the hearing officer deems necessary for the proper disposition of an appeal, including the following:
 - a. Disqualify himself or herself from the case;
 - b. Continue the hearing to a future date or time;
 - c. Prior to the entry of a final decision, reopen the hearing to take additional evidence;
 - d. Deny or dismiss an appeal or request for hearing in accordance with the provisions of this Article;
 - e. Exclude non-party witnesses from the hearing room; and
 - 11. Issue a written decision resolving the appeal.

R6-17-909. Change of Hearing Officer: Challenges for Cause

- A.** A party may request a change of hearing officer as prescribed in A.R.S. § 41-1992(B) by filing an affidavit which shall include:
 - 1. The case name and number;
 - 2. The hearing officer assigned to the case; and
 - 3. The name and signature of the party requesting the change.
- B.** The party requesting the change shall file the affidavit with the Office of Appeals and send a copy to all other parties at least five days before the scheduled hearing date.
- C.** Unless a party is challenging a hearing officer for cause under subsection (E), a party may request only one change of hearing officer.
- D.** A party may not request a change of hearing officer once the hearing officer has heard and decided a substantive motion, except as provided in subsection (E).
- E.** At any time before a hearing officer renders a decision, a party may challenge a hearing officer on the grounds that the hearing officer is not impartial or disinterested in the case.
- F.** A party who brings a challenge for cause shall file an affidavit as provided in subsection (A) and send a copy of the affidavit to all other parties. The affidavit shall explain the reason why the assigned hearing officer is not impartial or disinterested.
- G.** The hearing officer being challenged for cause may hear and decide the challenge unless:
 - 1. A party specifically requests that another hearing officer make the determination, or
 - 2. The assigned hearing officer disqualifies himself or herself from the decision.
- H.** The Office of Appeals shall transfer the case to another hearing officer when:
 - 1. A party requests a change as provided in subsections (A) through (D), or
 - 2. The hearing officer is removed for cause as provided in subsections (E) through (G).
- I.** The Office of Appeals shall send the parties written notice of the new hearing officer assignment.

Notices of Exempt Rulemaking

R6-17-910. Subpoenas

- A.** A party who wishes to have a witness testify at a hearing, or to offer a particular document or item in evidence, shall first attempt to obtain the witness or evidence by voluntary means. Department documents are available to the appellant as prescribed in R6-17-911(2).
- B.** If the party cannot procure the voluntary attendance of the witness or production of the evidence, the party may ask the hearing officer assigned to the case to issue a subpoena for a witness, document, or other physical evidence, or to otherwise obtain the requested evidence.
- C.** The party seeking the subpoena shall send the hearing officer a written request for a subpoena. The request shall include:
 - 1. The case name and number;
 - 2. The name of the party requesting the subpoena;
 - 3. The name and address of any person to be subpoenaed, with a description of the subject matter of the witness's anticipated testimony;
 - 4. A description of any documents or physical evidence to be subpoenaed, including the title, appearance, and location of the item if the appellant knows its location, and the name and address of the person in possession of the item;
 - 5. A statement as to the expected substance of the testimony or other evidence, as well as the relevance and importance of the requested testimony or other evidence; and
 - 6. A description of the party's efforts to obtain the witness or evidence by voluntary means.
- D.** A party who wants a subpoena shall ask for the subpoena at least five days before the scheduled hearing date.
- E.** The hearing officer shall deny the request if the witness's testimony or the physical evidence is not relevant to an issue in the case or is cumulative.
- F.** The Office of Appeals shall prepare all subpoenas and serve them by mail, except that the Office of Appeals may serve subpoenas to state employees who are appearing in the course of the employee's state employment, by regular mail, hand-delivery, electronic, or interoffice mail.

R6-17-911. Parties' Rights

A party to a hearing has the following rights:

- 1. The right to request a postponement of the hearing, as provided in this Article;
- 2. The right to copy, before or during the hearing, any documents in the Department's file on the appellant and documents the Department may use at the hearing, except documents shielded by the attorney-client or work-product privilege, or as otherwise prohibited by federal or state confidentiality laws;
- 3. The right to request a change of hearing officer as provided in A.R.S. § 41-1992(B) and R6-17-910;
- 4. The right to request subpoenas for witnesses and evidence as provided in R6-17-910;
- 5. The right to present the case in person or through an authorized representative, subject to any limitations prescribed in the Rules of the Supreme Court of Arizona, Rule 31;
- 6. The right to present evidence and to cross-examine witnesses; and
- 7. The right to further appeal, as provided in R6-17-918 and R6-17-920, if dissatisfied with an Office of Appeals' decision.

R6-17-912. Withdrawal of an Appeal

- A.** An appellant may withdraw an appeal verbally or in writing at any time prior to the time the hearing officer renders a decision.
 - 1. An appellant may withdraw an appeal verbally in person or by telephone. The Department may audiotape the withdrawal.
 - 2. An appellant may withdraw an appeal by signing a written statement expressing the intent to withdraw. The Department shall make a withdrawal form available for this purpose.
- B.** The Office of Appeals shall dismiss the appeal upon receipt of a withdrawal request signed by the appellant or the appellant's representative, or a statement of withdrawal made on the record, when the hearing officer has accepted the withdrawal.

R6-17-913. Failure to Appear; Default; Reopening

- A.** If an appellant fails to appear at the scheduled hearing, the hearing officer shall:
 - 1. Enter a default and issue a decision dismissing the appeal, except as provided in subsection (B);
 - 2. Rule summarily on the available record; or
 - 3. Adjourn the hearing to a later date and time.
- B.** The hearing officer shall not enter a default if the appellant notifies the Office of Appeals, before the scheduled time of hearing, that the appellant cannot attend the hearing, due to good cause, and still desires a hearing or wishes to have the matter considered on the available record.
- C.** No later than 10 days after a scheduled hearing date at which a party failed to appear, the non-appearing party may file a request to reopen the proceedings. The request shall be in writing and shall demonstrate good cause for the party's failure to appear.

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- D. The hearing officer shall set the matter for a hearing to determine whether the appellant had good cause for the appellant's failure to appear.
- E. If the hearing officer finds that the party had good cause for non-appearance, the hearing officer shall reopen the proceedings and schedule a de novo hearing with notice to all interested parties as prescribed in R6-17-907(C).
- F. Good cause, for the purpose of reopening a hearing, is established if the failure to appear at the hearing and the failure to timely notify the hearing officer were beyond the reasonable control of the non-appearing party. Good cause also exists when the non-appearing party demonstrates excusable neglect for both the failure to appear and the failure to timely notify the hearing officer. "Excusable neglect" has the meaning applied to "excusable neglect" as that term is used in Arizona Rules of Civil Procedure, Rule 60(c).

R6-17-914. Hearing Proceedings

- A. The hearing is a de novo proceeding. The Department has the initial burden of going forward with evidence to support the adverse action being appealed.
- B. To prevail, the appellant shall prove, by a preponderance of the evidence, that the Department's action was unauthorized, unlawful, or an abuse of discretion.
- C. The Arizona Rules of Evidence do not apply at the hearing. The hearing officer may admit and give probative effect to evidence as prescribed in A.R.S. § 23-674(D).
- D. The Office of Appeals shall record all hearings. The Department need not transcribe the proceedings unless a transcription is required for further administrative or judicial proceedings.
- E. The Office of Appeals charges a fee of 15¢ per page for providing a transcript. A party may obtain a waiver of the fee by submitting an affidavit stating that the party cannot afford to pay for the transcript.
- F. A party may, at his or her own expense, arrange to have a court reporter present to transcribe the hearing, provided that such transcription does not delay or interfere with the hearing. The Department's recording of the hearing shall constitute the official record of the hearing.
- G. The hearing officer shall call the hearing to order and dispose of any pre-hearing motions or issues.
- H. With the consent of the hearing officer, the parties may stipulate to factual findings or legal conclusions.
- I. Upon request and with the consent of the hearing officer, a party may make opening and closing statements. The hearing officer shall consider any statements as argument and not evidence.
- J. A party may testify, present evidence, and cross-examine adverse witnesses. The hearing officer may also take witness testimony or admit documentary or physical evidence on his or her own motion.
- K. The hearing officer shall keep a complete record of all proceedings in connection with an appeal.
- L. The hearing officer may require the parties to submit memoranda on issues in the case if the hearing officer finds that the memoranda would assist the hearing officer in deciding the case. The hearing officer shall establish a briefing schedule for any required memoranda.

R6-17-915. Hearing Decision

- A. No later than 60 days after the date the appellant files a request for hearing with the Department, the hearing officer shall render a decision based solely on the evidence and testimony produced at the hearing, and the applicable law. The 60-day time limit is extended for any delay caused by the appellant.
- B. The hearing decision shall include:
 1. Findings of fact concerning the issue on appeal;
 2. Citations to the law and authority applicable to the issue on appeal;
 3. A statement of the conclusions derived from the controlling facts and law, and the reasons for the conclusions;
 4. The name of the hearing officer;
 5. The date of the decision; and
 6. A statement of further appeal rights and the time period for exercising those rights.
- C. The Office of Appeals shall mail a copy of the decision to each party's representative, or to the party if the party is unrepresented.

R6-17-916. Effect of the Decision

- A. If the hearing officer affirms the adverse action against the appellant, the adverse action is effective as of the date of the initial determination of adverse action by the Department. The adverse action remains effective until the appellant appeals and obtains a higher administrative or judicial decision reversing or vacating the hearing officer's decision.
- B. If the hearing officer reverses the Administration's decision to take adverse action, the Administration shall not take the action or shall reverse any adverse action taken unless and until the Appeals Board or Arizona Court of Appeals issues a decision affirming the adverse action.

R6-17-917. Further Administrative Appeal

- A. A party may appeal an adverse decision issued by a hearing officer to the Department's Appeals Board, as prescribed in A.R.S. § 41-1992(C) and (D), by filing a written petition for review with the Office of Appeals within 15 days of the mailing date of the hearing officer's decision.

Notices of Exempt Rulemaking

- B.** The petition for review shall:
 - 1. Be in writing.
 - 2. Describe why the party disagrees with the hearing officer's decision, and
 - 3. Be signed and dated by the party or the party's representative.
- C.** The party petitioning for review shall mail a copy of the petition to all other parties.
- D.** The Appeals Board shall have the proceedings of the hearing below transcribed.

R6-17-918. Appeals Board

- A.** The Appeals Board shall conduct proceedings in accordance with A.R.S. § 41-1992(D) and A.R.S. § 23-672.
- B.** Following notice to the parties, the Appeals Board may receive additional evidence or hold a hearing if the Appeals Board finds that additional information would help in deciding the appeal. The Board may also remand the case to the Office of Appeals for rehearing, specifying the nature of the additional evidence required, or any further issues to be considered.
- C.** The Appeals Board shall decide the appeal based solely on the record of proceedings before the hearing officer and any further evidence or testimony presented to the Board.
- D.** The Appeals Board shall issue, and mail to all parties, a final written decision affirming, reversing, setting aside, or modifying the hearing officer's decision. The Board's decision shall specify the parties' rights to further review and the time for filing a request for review.

R6-17-919. Judicial Review

Any party adversely affected by an Appeals Board decision may seek judicial review as prescribed in A.R.S. § 41-1993.

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ADMINISTRATION**

PREAMBLE

- 1. Sections Affected**

R9-22-101	Amend
Article 21	New Article
R9-22-2101	New Section
R9-22-2102	New Section
R9-22-2103	New Section
- 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. § 36-2903.07
Implementing statute: A.R.S. § 36-2903.07
- 3. The effective date of the rules:**

October 19, 2003
- 4. A list of all previous notices appearing in the Register addressing the exempt rules:**

Notice of Rulemaking Docket Opening: 9 A.A.R. 183, January 24, 2003
Notice of Rulemaking Docket Opening: 9 A.A.R. 1203, April 11, 2003
Notice of Proposed Exempt Rulemaking: 9 A.A.R. 3130, July 18, 2003
- 5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name: Claire Sinay
Address: AHCCCS
Office of Special Programs
701 E. Jefferson, Mail Drop 8500
Phoenix, AZ 85034
Telephone: (602) 417-4178
Fax: (602) 254-1769
- 6. An explanation of the rules, including the agency's reasons for initiating the rules, including the statutory citation to the exemption from the regular rulemaking procedures:**

Proposition 202 (the Indian Gaming Preservation and Self-Reliance Act), approved by Arizona voters in November 2002, allocates Indian gaming revenues to the Trauma and Emergency Services Fund. Monies in the fund are to be used to reimburse hospitals in Arizona for unrecovered trauma center readiness costs and unrecovered emergency services costs.

A new section of state statute, A.R.S. § 36-2903.07(E), requires AHCCCS to promulgate rules for the Trauma and Emergency Services Fund and exempts the rulemaking from the provisions of Title 41, Chapter 6, Article 5. The rule prescribes the manner in which the monies are allocated and distributed.
- 7. A reference to any study relevant to the rules that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

The Administration did not review any study relevant to these rules.
- 8. A showing of good cause why the rules are necessary to promote a statewide interest if the rules 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:**

Proposition 202, approved by the voters in November 2002, provides an exemption from the provisions of Title 41, Chapter 6, Article 5 under A.R.S. § 36-2903.07(E).

Notices of Exempt Rulemaking

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:

PRINCIPAL COMMENTS	AHCCCS RESPONSE
<p>Arizona Hospital and Healthcare Association (AzHHA) AZHHA advocates for a statewide redistribution of the funds that would have gone to the closing level I trauma center</p> <p>R9-22-2101(E)(2): Change language to read “Using the data under subsection (D) of this Section, the Administration shall calculate the payment that would have gone to the closing level I trauma center and distribute that payment in accordance with R9-22-2102 one year following the closure of the level I trauma center.”</p>	<p>The current language redistributes the funds to the remaining level I trauma center(s) in the county in which the closure occurs.</p> <p>AHCCCS believes that by distributing the appropriate amount of funds back to the community in which the care will be provided will help to ensure that trauma services are available where and when needed.</p> <p>AHCCCS will not amend the language.</p>
<p>Arizona Department of Health and Human Services (ADHS) ADHS read a statement in support of the rule.</p>	None needed

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:

Not applicable

14. Were these rules previously adopted as emergency rules?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ADMINISTRATION**

ARTICLE 1. DEFINITIONS

Section

R9-22-101. Location of Definitions

ARTICLE 21. TRAUMA AND EMERGENCY SERVICES FUND

Section

R9-22-2101. General Provisions

R9-22-2102. Distribution of Trauma and Emergency Services Fund: Level I Trauma Centers

R9-22-2103. Distribution of Trauma and Emergency Services Fund: Emergency Services

ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

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

“Accommodation” R9-22-107

“Act” R9-22-114

Notices of Exempt Rulemaking

“Active case”	R9-22-109
“ADHS”	R9-22-112
“Administration”	A.R.S. § 36-2901
“Administrative law judge”	R9-22-108
“Administrative review”	R9-22-108
“Advanced Life Support” or “ALS”	R9-25-101
“Adverse action”	R9-22-114
“Affiliated 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 inpatient hospital day or days of care”	R9-22-107
“AHCCCS registered provider”	R9-22-101
“Ambulance”	A.R.S. § 36-2201
“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
“Attending physician”	R9-22-101
“Authorized representative”	R9-22-114
“Auto-assignment algorithm”	R9-22-117
“Baby Arizona”	R9-22-114
“Basic Life Support” or “BLS”	R9-25-101
“Behavior management services”	R9-22-112
“Behavioral health evaluation”	R9-22-112
“Behavioral health medical practitioner”	R9-22-112
“Behavioral health professional”	R9-20-101
“Behavioral health service”	R9-22-112
“Behavioral health technician”	R9-20-101
“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
“Burial plot”	R9-22-114
“Capital costs”	R9-22-107
“Capped fee-for-service”	R9-22-101
“Caretaker relative”	R9-22-114
“Case”	R9-22-109
“Case record”	R9-22-109
“Case review”	R9-22-109
“Cash assistance”	R9-22-114
“Categorically-eligible”	R9-22-101

Notices of Exempt Rulemaking

“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”	A.R.S. § 36-2901
“Copayment”	R9-22-107
“Corrective action plan”	R9-22-109
“Cost-to-charge ratio”	R9-22-107
“Covered charges”	R9-22-107
“Covered services”	R9-22-102
“CPT”	R9-22-107
“CRS”	R9-22-114
“Cryotherapy”	R9-22-120
“Date of eligibility posting”	R9-22-107
“Date of notice”	R9-22-108
“Day”	R9-22-101
“DCSE”	R9-22-114
“De novo hearing”	42 CFR 431.201
“Dentures”	R9-22-102
“Department”	A.R.S. § 36-2901
“Dependent child”	A.R.S. § 46-101
“DES”	R9-22-101
“Diagnostic services”	R9-22-102
“Director”	R9-22-101
“Disabled”	R9-22-115
“Discussions”	R9-22-106
“Disenrollment”	R9-22-117
“District”	R9-22-109
“DME”	R9-22-102
“DRI inflation factor”	R9-22-107
“E.P.S.D.T. services”	42 CFR 441 Subpart B
“Eligible person”	A.R.S. § 36-2901
“Emergency medical condition”	42 U.S.C. 1396b(v)(3)
“Emergency medical services”	R9-22-102
<u>“Emergency services costs”</u>	<u>A.R.S. § 36-2903.07</u>
“Encounter”	R9-22-107
“Enrollment”	R9-22-117
“Enumeration”	R9-22-101
“Equity”	R9-22-101
“Experimental services”	R9-22-101
“Error”	R9-22-109
“FAA”	R9-22-114
“Facility”	R9-22-101

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“Factor”	42 CFR 447.10
“FBR”	R9-22-101
“Fee-For-Service” or “FFS”	R9-28-101
“FESP”	R9-22-101
“Finding”	R9-22-109
“First-party liability”	R9-22-110
“Foster care maintenance payment”	42 U.S.C. 675(4)(A)
“Federal poverty level” (“FPL”)	A.R.S. § 1-215
“FQHC”	R9-22-101
“Grievance”	R9-22-108
“GSA”	R9-22-101
“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
“Intermediate Care Facility for the Mentally Retarded” or “ICF-MR”	42 CFR 483 Subpart I
“ICU”	R9-22-107
“IHS”	R9-22-117
“IMD”	42 CFR 435.1009 and R9-22-112
“Income”	R9-22-114
“Inmate of a public institution”	42 CFR 435.1009
“Interested party”	R9-22-106
“LEEP”	R9-22-120
“ <u>Level I trauma center</u> ”	<u>R9-22-2101</u>
“License” or “licensure”	R9-22-101
“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”	A.R.S. § 36-401
“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”	A.R.S. § 36-2901
“Mental disorder”	A.R.S. § 36-501
“New hospital”	R9-22-107
“Nursing facility” or “NF”	42 U.S.C. 1396r(a)
“NICU”	R9-22-107
“Noncontracting provider”	A.R.S. § 36-2901
“Nonparent caretaker relative”	R9-22-114
“Notice of Findings”	R9-22-109

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“OAH”	R9-22-108
“Occupational therapy”	R9-22-102
“Offeror”	R9-22-106
“Ownership interest”	42 CFR 455.101
“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
“Prior period coverage” or “PPC”	R9-22-107
“Post-stabilization care services”	42 CFR 422.113
“Practitioner”	R9-22-102
“Pre-enrollment process”	R9-22-114
“Preponderance of evidence”	R9-22-109
“Prescription”	R9-22-102
“Primary care provider (PCP)”	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
“Psychiatrist”	R9-22-112
“Psychologist”	R9-22-112
“Psychosocial rehabilitation services”	R9-22-112
“Qualified alien”	A.R.S. § 36-2903.03
“Quality management”	R9-22-105
“Radiology”	R9-22-102
“Random sample”	R9-22-109
“RBHA”	R9-22-112
“Rebasing”	R9-22-107
“Referral”	R9-22-101
“Rehabilitation services”	R9-22-102
“Reinsurance”	R9-22-107
“Remittance advice”	R9-22-107
“Resources”	R9-22-114
“Respiratory therapy”	R9-22-102
“Respondent”	R9-22-108
“Responsible offeror”	R9-22-106
“Responsive offeror”	R9-22-106
“Review”	R9-22-114

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“Review period”	R9-22-109
“RFP”	R9-22-106
“Scope of services”	R9-22-102
“SDAD”	R9-22-107
“Section 1115 Waiver”	A.R.S. § 36-2901
“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
“Speech therapy”	R9-22-102
“Spendthrift restriction”	R9-22-114
“Spouse”	R9-22-101
“SSA”	42 CFR 1000.10
“SSI”	42 CFR 435.4
“SSN”	R9-22-101
“Stabilize”	42 U.S.C. 1395dd
“Standard of care”	R9-22-101
“Sterilization”	R9-22-102
“Subcontract”	R9-22-101
“Submitted”	A.R.S. § 36-2904
“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-D”	R9-22-114
“Title IV-E”	R9-22-114
“Tolerance level”	R9-22-109
<u>“Trauma and Emergency Services Fund”</u>	<u>A.R.S. § 36-2903.07</u>
<u>“Unrecovered trauma readiness costs</u>	<u>R9-22-2101</u>
“Utilization management”	R9-22-105
“WWHP”	R9-22-120

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 registered provider” means a provider or noncontracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A); and

Meets license or certification requirements to provide AHCCCS covered services.

“Applicant” means a person who submits or whose authorized representative submits, a written, signed, and dated application for AHCCCS benefits.

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

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

“Attending physician” means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a fee-for-service member.

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“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 or equipment provided to a member. A payment is made in accordance with an upper, or capped, limit established by the Director.

“Categorically-eligible” means a person who is eligible under A.R.S. §§ 36-2901(6)(a)(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 this Chapter.

“Day” means a calendar day unless otherwise specified.

“DES” means the Department of Economic Security.

“Director” means the Director of the Administration or the Director’s designee.

“Eligible person” means a person as defined in A.R.S. § 36-2901.

“Enumeration” means the assignment of a specific 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.

“Experimental services” means services that are associated with treatment or diagnostic evaluation that meets one or more of the following criteria:

Is not generally and widely accepted as a standard of care in the practice of medicine in the United States;

Does not have evidence of safety and effectiveness documented in peer reviewed articles in medical journals published in the United States; or

Lacks authoritative evidence by the professional medical community of safety and effectiveness because the services are rarely used, novel, or relatively unknown in the professional medical community.

“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 service.

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

“FESP” means a federal emergency services program covered under R9-22-217, to treat an emergency medical condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

“FQHC” means federally qualified health center.

“GSA” means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with that contractor.

“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, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.

“License” or “licensure” means a nontransferable authorization that is awarded 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 lawfully render a health care service.

“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.

“Medically necessary” means a covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or prolong life.

“Medicare HMO” means a health maintenance organization that has a current contract with Centers for Medicare and Medicaid for participation in the Medicare program under 42 CFR 417(L).

“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.

“Service location” means a location at which a member obtains a covered health care service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

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“Service site” means a location designated by a contractor as the location at which a member is to receive covered health care services.

“SESP” means state emergency services program covered under R9-22-217 to treat an emergency medical condition for a qualified alien or noncitizen who is determined eligible under A.R.S. § 36-2901.06.

“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)(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 a person who has entered into a contract of marriage, recognized as valid by Arizona.

“SSN” means social security number.

“Standard of care” means a medical procedure or process that is accepted as treatment for a specific illness, or injury, medical condition through custom, peer review, or consensus by the professional medical community.

“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.

ARTICLE 21. TRAUMA AND EMERGENCY SERVICES FUND

R9-22-2101. General Provisions

- A.** A.R.S. § 36-2903.07 establishes the Administration as the authority to administer the Trauma and Emergency Services Fund.
- B.** The Administration shall distribute 90% of monies from the trauma and emergency services fund to a level I trauma center, as defined in subsection (F) of this Section, for unrecovered trauma center readiness costs as defined in subsection (F) of this Section. Reimbursement is limited to no more than the amount of unrecovered trauma center readiness costs as determined in subsections (D) and (E) of this Section. Unexpended funds may be used to reimburse unrecovered emergency room costs under subsection (C) of this Section.
- C.** The Administration shall distribute 10% of monies from the trauma and emergency services fund, for unrecovered emergency services costs, to a hospital having an emergency department, using criteria under R9-22-2103. Reimbursement is limited to no more than the amount of unrecovered emergency services costs as determined in R9-22-2103. The Administration may distribute more than 10% of the monies for unrecovered emergency room costs when there are unexpended monies under subsection (B) of this Section.
- D.** The Administration shall distribute a reporting tool and guidelines to level I trauma centers to determine, on an annual basis, the unrecovered trauma center readiness costs for level I trauma centers as defined in subsection (F) of this Section. The reporting time-frame is July 1 of the prior year through June 30 of the reporting year. A level I trauma center shall submit the requested data and a copy of the most recently completed uniform accounting report under A.R.S. § 36-125.04 to the Administration no later than October 31 of each reporting year.
- E.** When a level I trauma center closes in a county where there are one or more level I trauma center(s) remaining in operation, the following shall occur:
 - 1.** The closing level I trauma center shall submit the requested data under subsection (D) of this Section for the months of the reporting time-frame in which it met the definition of a level I trauma center, and
 - 2.** The data under subsection (D) of this Section, which is submitted by the closing level I trauma center, shall be added to the remaining level I trauma center(s) in that county for the current reporting time-frame only.
- F.** 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.** “Level I trauma center” means any acute care hospital that:
 - a.** Provides in-house 24-hour daily dedicated trauma surgical services as defined in A.R.S. § 36-2201(26) pertaining to a trauma center, or
 - b.** Is recognized as a rural regional trauma center that was providing formal organized trauma services on or before January 1, 2003.
 - 2.** On or after January 1, 2005, “level I trauma center” means any acute care hospital designated by the Arizona Department of Health Services as a level I trauma center.
 - 3.** “Unrecovered trauma center readiness costs” means losses incurred treating trauma patients:
 - a.** Determined in accordance with Generally Accepted Accounting Principles,
 - b.** Based on both clinical and professional costs incurred by a level I trauma center necessary for the provision of level I trauma care, and
 - c.** Based on administrative and overhead costs directly associated with providing level I trauma care.

Notices of Exempt Rulemaking

R9-22-2102. Distribution of Trauma and Emergency Services Fund: Level I Trauma Centers

A. On or after November 1, 2003, the Administration shall distribute monies, under R9-22-2101(B), to level I trauma centers using monies available in the trauma and emergency services fund at the time of payment. The Administration shall take into consideration the proportion of those hospitals' trauma case volume. The Administration shall:

1. Recalculate the November 2003 payments in July 2004 using the formula in subsection (B) of this Section;
2. Recoup November 2003 overpayments by reducing the July 2004 distributions under subsection (C) as appropriate; and
3. Redistribute recouped funds, with the July 2004 payment, to level I trauma centers underpaid in November 2003.

B. On or after January 31 of each year, the Administration shall distribute monies, under R9-22-2101(B), to level I trauma centers using monies available in the trauma and emergency services fund at the time of payment. The Administration shall determine each hospital's unrecovered trauma center readiness costs for the current fiscal year using data from the most recent reporting year as provided under R9-22-2101(D) and (E). The proportion of each hospital's share of the fund for unrecovered trauma center readiness costs is determined after considering:

1. The professional, clinical, administrative, and overhead costs directly associated with providing level I trauma care, and
2. The volume and acuity of trauma care provided by each hospital.

C. On or after July 31 of each year, the Administration shall distribute monies to level I trauma centers using monies, under R9-22-2101(B), available in the trauma and emergency services fund at the time of payment according to the proportions calculated and used for the January payments in the same year, under subsection (B) of this Section.

R9-22-2103. Distribution of Trauma and Emergency Services Fund: Emergency Services

On or after June 30 of each year, the Administration shall distribute monies available in the trauma and emergency services fund at the time of payment as follows:

1. As allocated under R9-22-2101(C),
2. To hospitals that had an emergency department from July 1 through June 30 of the prior year, and
3. On a pro rata share of each hospital's uncompensated care as a percentage of the total statewide uncompensated care provided by hospitals under subsection (2) as reported in the uniform accounting reports to the Arizona Department of Health Services under A.R.S. § 36-125.04.